KANSAS MEDICINE

JOURNAL OF THE KANSAS MEDICAL SOCIETY

Spring 1996 Volume 97, Number 1

- Complications of Intravenous Heparin Therapy
- Provision of Labor and Delivery Services
- Testicular Seminoma
- Medical Care and the Criminal Law
- Prevention of Hepatitis A

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VOLUME 97 • NUMBER 1 • SPRING 1996

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KANSAS MEDICINE (ISSN 8755-0059) is published quarterly by the Kansas Medical Society, 623 W. 10th Avenue, Topeka KS 66612. KMS membership includes a one-year subscription for which $15 is allocated from each member's dues. Rates to others: $65/yr domestic; $80/yr foreign. Printed by The Ovid Bell Press, Inc. Fulton MO. Second class postage paid at Topeka KS and at additional mailing offices. POSTMASTER: Send address changes to KANSAS MEDICINE, 623 W. 10th Avenue, Topeka KS 66612.

Indexed in *Hospital Literature Index* and *Index Medicus.* Available through University Microfilms. Listed in *CC/Clinical Practice.* Search Resource for Institute for Medical Information, Inc., and Medical Search, Inc.

ABOUT OUR LOGO

In January 1935, a new logo appeared on the cover of KANSAS MEDICINE for the first time. This device represents two stethoscopes: the original monaural type as used by Läennec, and the modern binaural variety. The logo was designed expressly for KANSAS MEDICINE by renowned graphic designer Bradbury Thompson, a native of Topeka and friend of two former editors of the journal, Dr. W.M. Mills and Dr. Lucien Pyle. As another former editor, Dr. Orville R. Clark, wrote in January 1955, the logo "has become as much a part of the journal as any of the features on the inside and is something which is ours alone."

After a particularly severe winter this year (notwithstanding all the talk about global warming), we are happy to feature a garden of spring and summer flowers — ardently hoping that a bunch of them will soon be blossoming in real profusion.

Driving past El Dorado Lake on the Kansas Turnpike in January, we observed snow piled around the bottoms of dead tree branches that stuck out of the frozen surface. They reminded one of a large bunch of chocolate kisses with long brown tails. The realization of what they truly were brought on a sudden wish for a short, short winter and an early spring. Now that it's arrived, let's hope it's here to stay!

This month's cover again features the work of Wichita native Stephen J. Miner, a cum laude graduate of the Wichita State University with a degree in fine arts. We last featured Mr. Miner's work on the cover of the March 1994 issue, a painting of apple blossoms. Mr. Miner attempts not only to represent the real form of nature, but also to capture its dynamic spirit. We think you will agree that he has done both very capably in this cover.

So farewell, Winter. Hello, Spring!

SCHOLARSHIPS FOR PHYSICIANS

Scholarship funds are available, through the Earl L. Mills Educational Trust, to qualifying Kansas physicians for study in medicine or health care lasting 4 to 12 months at an approved institution. Applicants must have practiced continuously in Kansas for at least 5 years and may not be a member of a group of participating physicians larger than 5.

In addition, the Mills Trust provides funding for educational seminars in Sedgwick County, Kansas, which support postgraduate medical opportunities for practicing physicians.

The deadline for applications is July 31, 1996. Write the Earl L. Mills Educational Trust, INTRUST Bank, N.A., Attn: Carolyn A. Parmer, P.O. Box One, Wichita, Kansas 67201-5001.

Who'd a Thought?

Technology has burgeoned in recent years, and television and the computer have changed the practice of medicine. Doctors have faced the changes and adapted to many of them as they have arrived and their value has become known. Not all innovations prove worthy, however. Some, such as gastric freezing, gastric stapling, the gastric balloon, pneumoencephalogram, etc., have quietly disappeared.

One recent techno-advance is telemedicine, perhaps a natural extension of electronic commercialism. Electronic shopping, banking, securities trading, travel arrangements, and a host of other activities have been made available to the public without having to leave one's home or work place. Now telemedicine has arrived, offering the "best" physicians for consultation and treatment. The *Wall Street Journal* on January 17, 1996, ran an article on this subject called "Hold the Phone." In it, past KMS President Dr. Richard Meidinger was quoted regarding some proposed curbs on its use in Kansas.

The first three paragraphs of the article set the stage and gave readers some idea of what telemedicine is:

> In a small room here at the University of Kansas Medical Center, Gary Doolittle chats with a patient, checks her heart and lungs with a stethoscope and then asks her to step behind a screen and disrobe.
>
> A common exam, done in a most unusual way: the patient is in Hays, Ks., nearly 300 miles away. Dr. Doolittle, a 37-year-old oncologist, can examine patients across the state with gadgets like two-way television, electronic stethoscopes, and long distance X-ray transmission.
>
> It is called telemedicine, and to Dr. Doolittle, this is the "perfect use of the technology....Patients are getting the same kind of care they'd get if they were sitting next to me."

Arthur Caplan, professor of bioethics at the University of Pennsylvania, is also quoted in the article and states, "Technologically, telemedicine is already here." He later admits that overcoming the economic barriers "may take 20 years."

As usual, from the reporter's point of view, the opposition to this new "marvel" represents a turf battle among physicians as well as an economic threat to them. However, many insurers do not at present cover telemedicine and appear reluctant to do so. Many lawyers are concerned about the malpractice possibilities, as well as issues regarding privacy — especially in the area of HIV-positive patients.

The article is worth reading. Every advance in medicine has been both a blessing and a curse, depending on how the particular innovation was used. Penicillin was supposed to rid the world of infections once and for all, yet more and more resistant strains of bacteria continue to demand new and better antibiotics to eradicate them. Gastric freezing was to be the end to ulcer disease, yet the complication rate was prohibitive. Other similar examples can be found. It is highly possible that charlatans and quacks will take advantage of the new technology for their own personal gain — against the best interests of patients.

Another thing that bothers me about telemedicine is the problem of preserving the doctor-patient relationship. Clearly, in Dr. Doolittle's case it is a convenience that spares both doctor and patient much travel time and saves the patient considerable expense in getting a check-up. Furthermore, this is Dr. Doolittle's patient, one he has already seen in the flesh, and treated. He is a licensed Kansas physician. Such an arrangement would be considered a good use of this tool.

My concern is for the Kansas patient "seen" and treated by an out-of-state practitioner — and I don't believe my scenario is far-fetched. What recourse does that patient have if something untoward happens? Can that out-of-state doctor be held responsible? Should one be allowed to practice in a state where one is not licensed? State licensure boards were established to protect the public from fraudulent and unscrupulous practitioners, and to make sure that proper recourse was available for wronged patients. Is it not logical that those who would profit from such technology should be licensed to practice medicine in the state in which they practice, and submit to the regulations set by that state for similar practitioners?

The Kansas Medical Society has proposed amendments to the Healing Arts Act dealing with the interstate practice of medicine. One amendment would add to the list of persons not

engaged in the practice of medicine, to include: "Practitioners of the healing arts licensed in another state, whose professional services are performed in consultation with a practitioner who is licensed under this act, and who do not maintain an office or place to regularly examine or treat patients or to receive calls within this state."

KMS proposes to add under the section dealing with exceptions to the practice of the healing arts this addition: "(b) For the purpose of this act, each person, regardless of location, who performs for COMPENSATION any diagnostic or treatment services through the use of any medium, including an electronic medium, on an individual located in this state, shall be deemed to be engaged in the practice of the healing arts in this state and shall be required to be duly licensed except as otherwise provided by this act."

I admit to being an old dinosaur. Having a patient to see, question and examine in the flesh is still the best way, in my humble opinion. I know, however, that younger physicians who have grown up with television and the computer and use it regularly may feel differently and see this new technology as just another advance in medical treatment.

It might well be asked, does the concept of the physician-patient relationship still have any meaning? Is it still relevant in an age of depersonalization? I hope it is still one principle that the profession stands fully behind, because I think if it is swept away by the new electronic age, the profession and humanity as a whole will suffer.

This is not a turf issue; it is not an economic issue; it is not a jealousy issue. It is an issue of what is best for the patient — and that must concern every physician in Kansas. **W.E.M.**

Information for Authors

Manuscripts must be typewritten, double-spaced, leaving wide margins. The original plus one copy should be submitted. Manuscripts are received with the explicit understanding that they are not simultaneously under consideration by any other publication. Publication elsewhere may be subsequently authorized at the discretion of the editor.

Brief, concise **articles** are preferred; an ideal manuscript will not exceed five double-spaced pages. All material will be edited by the editorial staff to assure clarity, good grammar and appropriate language, and to conform to KANSAS MEDICINE style and format. When feasible, material may be condensed.

The author will be asked to review the **galley proof** prior to publication. Although editing and proofreading will be done with care, the author is responsible for accuracy of material published. The galley proof is for correction of ERRORS; rewriting of material *must* be done prior to submission. Authors are urged to check manuscripts and galley proof carefully for errors that could result in inaccurate information.

Drugs should be referred to by generic names; trade names may follow in parentheses if useful. All **units of measure** must be given in the metric system.

KANSAS MEDICINE will print a maximum of **ten references**. All references should be keyed with superscripts in the text in the order cited. If more than ten sources are cited, readers will be referred to the author for the complete list.

Illustrative material must be identified by its referral number in the text and be accompanied by a short legend. **Photos** should be black-and-white glossy prints. **Tables** should be self-explanatory and should supplement, not duplicate, the text.

KANSAS MEDICINE will assume the cost of black-and-white figures and tables for two units. A unit is defined as 1/4 page. The author(s) will be billed for additional units at cost.

A **reprint** order form with a table showing estimated cost will be sent with the galley proof. Reprints must be ordered by the author through KANSAS MEDICINE, and will be billed to the author following shipment.

Working Together to Make Our Future a Reality

Last May the theme for the KMS Annual Meeting was "Facing the Future Together." In my address to the House of Delegates, I spoke of challenges and frontiers that we were facing, and I proposed some mechanisms for working together to arrive at the best solutions for problems and changes facing Kansas physicians. We have implemented some of these areas, and others have been explored and developed as the environment has changed in the past year.

One of our primary objectives has been to explore ways that we can improve communication amongst physicians so that the physician community can truly have an understanding of each other's issues and thereby be willing to work together as a unit to solve problems. To initiate some of this dialogue, we formed an interspecialty council which met and discussed problems facing each of the respective specialties. Interestingly, many of the issues which each group thought were unique to their own specialty actually involved large segments of Kansas medicine. To have all physicians come to the table and work toward solutions was most beneficial.

Along the same lines, the Task Force on Practice Issues dealt with the topics of mid-level practitioners and how "scope of practice" and "supervision" affect the delivery of quality-care medicine in Kansas. Input on this task force was received from all specialties, and further understanding and cooperation amongst Kansas physicians was achieved.

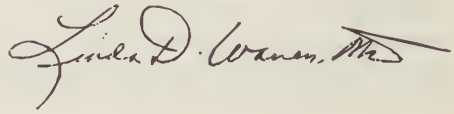
The western Kansas office, situated in Hays, is rapidly becoming a reality. Staff and location have been selected, and the opening date was set for April 24. I am most pleased with the support I have received — from across the state — in this effort to extend the KMS presence into western Kansas. We hope this will be only the beginning of such outreach efforts of the Kansas Medical Society to maintain communications and promote the "community of physicians" as truly being all the physicians within the four borders of our state.

We have reactivated the KMS/KUMC Liaison Committee and are most pleased with the response to the initial meeting. Issues of common concern were discussed, and ways that KU and KMS can assist one another were explored. The participants from both groups were enthusiastic and voted to continue with regular meetings four times a year.

The legislative battles are ongoing. This year we have met with many groups representing different types of practitioners. With some we have been able to find common ground and proceed with legislative efforts in a manner we feel will continue to offer quality medical care to our patients; optometry and nurse anesthesia are two of these. With others, we have felt that compromise was not possible because we must always look at the quality of care and work toward protecting that for our patients.

The environment of medicine continues to change. We are seeing many of our physicians across the state, both metropolitan and rural, aligning themselves with large managed care groups. Many physicians are selling their practices to managed care groups or hospitals. As this trend has developed, we have perceived a need for KMS to create a management services organization (MSO) to assist physicians in today's economic world. A feasibility study is in progress on this topic, and a report will be presented to the House of Delegates in May.

This is only a brief summary of some of KMS' activities in 1995-96 and some of my directions as president. What it does not show are the faces and voices of the physicians I've worked with this past year as I traveled across the state — the faces and voices that express love and dedication to the patients of our state and show their eternal commitment to preserving quality care for the people. The physicians of Kansas are truly a very special family, and I thank you for the privilege of serving as President this year.



This Has Been a Great Year, Thanks to You!

What a great year this has been for the Kansas Medical Society Alliance! So much has been accomplished, and many goals have been attained. But the greatest accomplishment is the ongoing relationship between the Kansas Medical Society and the Alliance. My predecessors had related to me this unique relationship between the two groups, but I didn't comprehend what a wonderful working relationship we have.

Dr. Linda Warren and Jerry Slaughter are two of the greatest supporters of the Alliance. Dr. Warren has taken an active role as both an Alliance member and a dedicated supporter. There has been no project the Alliance has undertaken this year in which Dr. Warren hasn't played a major part.

At the beginning of the year, KMS gave the Alliance $10,000 to be donated to the American Medical Association Education and Research Foundation on behalf of Dr. Linda Warren's campaign for a position on the AMA Committee on Constitution and Bylaws. AMA-ERF is the only philanthropy the Kansas Medical Society Alliance supports on the state level. The money that KMS gave helped us to have a banner year — in fact, we set a record with our contributions.

Our two major statewide health promotion projects were the SAVE program (Stop America's Violence Everywhere) and the bone-marrow donor drive. Dr. Warren purchased SAVE pins for herself, her husband and her entire office staff to wear in support of our SAVE Day. Half of the purchase price of these pins went to AMA-ERF. When approached with the Alliance's bone-marrow donor drive, Dr. Warren discussed this program with physicians she met across the state and also signed up 15 prospective donors through her office in Hanover. This was one of the largest recruitment groups we have had throughout the state.

Our membership has always been a concern of Dr. Warren, and she often asks what she can do to increase our membership. The Kansas Medical Society has over 4,000 members, whereas the Alliance is working hard to maintain a member ship of 900. So whenever possible, Dr. Warren would praise the work of the Alliance to physicians and urge them to encourage their spouses to join our organization. She understands the strength of having an organization of both physicians and their spouses, since she herself fits both categories.

Dr. Warren is a cherished friend of the Alliance, and she will always be a cherished friend of mine. This year has truly been special due to her support and friendship. I feel very blessed to have served the Alliance at the same time Dr. Warren was President of the KMS.

Jerry Slaughter is also a member of our Alliance and a great supporter of our projects. He, along with his office staff, is always willing to help our members by supplying us with legislative information, health project resources, and space in the office building when needed.

This year we finished a project that has taken years to complete. With Jerry's support, Mary Waxse and Katie Pyle assembled photographs of the Alliance's past presidents. The pictures have been framed and are on display in the KMS Building, where they look great alongside the KMS past presidents' photos. Without Jerry's support, this project could not have been done.

The biggest part that Jerry plays in the success of the Alliance is unselfishly "loaning" Nancy Sullivan to act as our "Executive Director." Nancy is a delight to work with and is so multi-talented! Without her help our Alliance would be only half as effective as it is. Nancy knows every aspect of the Alliance, past and present. She keeps us on target, holds us to our deadlines (which is very hard to do), and keeps us informed of what is happening at the KMS. She is instrumental in planning our board meetings and works very closely with the Alliance in planning the state convention. This year Nancy attended Confluence in Chicago with our county presidents-elect so she could stay up-to-date with AMAA. Nancy is a true friend to our Alliance and is indispensable. We hope she will work with us for many years to come.

(Continued on page 9.)

Health care remains under a national microscope. Every aspect of its delivery system has been scrutinized, poked and prodded. That makes what you do tougher. And adds pressure to a job that comes with plenty already built in.

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Medical Care and the Criminal Law

WAYNE T. STRATTON, J.D.,* *Topeka*

It is the nature of medical care that physicians frequently face life-and-death decisions. On occasion they may be drawn into situations in which wills are contested or the ownership of property is litigated. Since patients often confide in their physicians, others may try to invade the privacy of the doctor-patient relationship. Patients themselves may ask their physicians to provide services that conflict with prevailing laws.

As indicated by the popular press, physicians' involvement with the criminal law seems to have increased. Kansas has recently seen cases in which physicians have been charged with the murder of their patients, or with utilizing their medical knowledge to cause the death of a spouse. Several months ago, a New York physician was found guilty of a homicide as a result of negligent care rendered to a woman.

While past columns have emphasized the importance for physicians of being sensitive to civil liability, little attention has been paid to the possibility of criminal charges that may be filed. Given the nature of the development of the law, one can assume that further involvement of prosecutors with health care may occur. Following is a brief primer on Kansas law as it relates to potential criminal conduct by a physician.

Differences between Civil and Criminal Law

Unlike civil cases, which can be brought by any interested party who has been wronged, the violation of the criminal law requires the prosecutor to pursue the case. Normally, this is the county or district attorney, but in some areas the city attorney may have some powers to prosecute in misdemeanor offenses. On rare occasions, the attorney general intervenes and assists in the prosecution of a case.

Ordinarily these cases are brought in the district court. A warrant may be issued, and the defendant is brought before a magistrate for a determination of the amount of the bond. A preliminary examination is held in which the court determines whether a crime has been committed and if there is probable cause to believe that it was committed by the defendant. If so, then the defendant is bound over for trial. An information is filed, and the case proceeds to trial.

Various statutory and constitutional protections exist which differ from the civil code. Among these are:

- A requirement that there be evidence to prove the guilt of the defendant beyond a reasonable doubt. This varies from the civil code, which only requires evidence that something is more likely true based on the preponderance of the evidence.
- The right to counsel.
- The right that statements of the defendant may be used against him or her only under certain circumstances.

Notwithstanding these procedural guarantees, the defense of the criminal case can be an overwhelming experience for a defendant. The state has many resources that can be utilized to focus upon an individual's conduct. Needless to say, any person who suspects that they may be a target of an investigation should immediately seek counsel.

Criminal Acts in Health Care

A few crimes are unique to physicians or other health care providers:

- K.S.A. 21-3406 relates to assisting suicide. This is defined as intentionally advising, encouraging or assisting another in the taking of the other's life, which results in a suicide or attempted suicide. While Dr. Jack Kevorkian has successfully avoided conviction in Michigan based on a similar statute, nevertheless physicians should be aware that prosecution is possible in

*KMS Legal Counsel.

Comments made herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 515 S. Kansas Ave., Topeka, Kansas 66603.

Kansas. However, the Legislature was careful, when it enacted the statute allowing a patient to make an advance determination to withhold or withdraw life-sustaining procedures, to provide that a physician who followed these procedures was not guilty of assisting suicide.

- A physician who knowingly conceals evidence that a patient has revoked his or her advance directive may be charged with a felony under the Kansas Natural Death Act.
- K.S.A. 21-3425 addresses a physician's mistreatment of a patient in a public or private hospital or nursing home. This statute makes it a crime to intentionally abuse, neglect, or treat in an ill manner a patient who is detained or confined and who is physically disabled, mentally ill or mentally retarded.
- K.S.A. 65-6703 defines criminal abortion. Kansas law prohibits performance or inducement of an abortion on a *viable* fetus. "Viable" is defined as a stage in which it is the "best medical judgment" of the physician that the fetus is capable of sustained life outside the uterus without extraordinary means to support its life. Instances in which Kansas allows abortions are when two physicians determine that: (1) the abortion is necessary to preserve the life of the pregnant woman; or (2) the fetus has a severe or life-threatening abnormality. Abortion is also legally acceptable when the woman's physician determines the fetus is not at a viable stage.
- In addition to the criminal abortion guidelines, there are extensive provisions relating to a minor's ability to receive an abortion from a physician. If a physician elects not to give parental notice, he or she must comply with the required reporting provisions. Any deviation from the abortion law's notice or reporting requirements is designated a crime under the laws of Kansas.
- Along with the reporting requirements under the abortion laws, Kansas has imposed other reporting duties upon physicians. It is a crime to knowingly fail to make a report when the physician has reasonable cause to believe that a child, adult resident of a care facility, or any adult unable to protect his or her own interests is being or has been abused. The law requires at least an oral report to be made to the state department of Social and Rehabilitation Services or, in the case of a child in an institution operated by the SRS secretary, the report should be made to the attorney general.

ALLIANCE NEWS

(Continued from page 6.)

As I traveled to AMAA meetings and visited with other state alliance presidents, it became obvious that our relationship with the KMS is indeed special. Very few state presidents are allowed to sit in on the medical society's executive committee and council meetings. I know of no other alliance presidents who travel with the medical society president to speak at council district meetings. Our joint installation of presidents is envied by other states, and our addressing of the KMS House of Delegates is a privilege many other state presidents can't imagine.

All the members of the Kansas Medical Society have made this a special year for me. I have been greeted and supported enthusiastically by the physicians of Kansas. The Alliance is respected by our physicians. I know this relationship will continue in the future, and I must thank the past KMS Alliance presidents for making it so outstanding. Our future looks bright, our organizations are strong, and Kansas will continue to be a leader in organized medicine.

Lisa Barker

Do You Have a Story to Tell?

In "The Rural Voice," a column making its debut on the following page, Dr. Richard Ohmart shares some of his Oakley experiences with us. For many Kansans, neither Ohmart's life style nor his practice style is unique. These Kansans share a spectrum of triumphs, tribulations and convictions that are characteristic of rural medical practice.

Nurturing a rural practice requires a certain Kansan approach. In states such as ours, health care often abides by a common-sense imperative that is rare these days. The current urban-centered corporate ethos of medicine does not hear the rural voice clearly. Capitation, web presence, deselection, teaching physician component and mergers are anemic clichés, concepts that ill serve the demands of health care in remote areas.

Statistics tell us many diverse facts about rural America: rural hospitals seldom make money from Medicare; in 1993, 83% of the nation's land and 20% of its population were rural; Medicare is the largest payer for rural hospitals; etc. These numbers are sterile cant if left to stand alone. They must be accompanied by descriptions and narratives of clinical experience. This is where we need your input. We would like you to tell us about how you solved a clinical problem using your pastoral wisdom, to offer your prairie solutions to sticky social situations or your avuncular advice for recent graduates headed for a rural practice. Perhaps you want to spotlight a little-known scientific or experiential facet of rural medicine.

To stimulate such an effort, we have asked Dr. Ohmart to write the inaugural article. His witty and often poignant columns in American Medical News are familiar to most of us. His talent as a raconteur has made Oakley, Kansas the real-life equivalent of Garrison Keillor's Lake Wobegon. We are happy that he has agreed to contribute periodically to KANSAS MEDICINE. As you chuckle, ponder or commiserate with him, perhaps your own muse, long in hibernation, will awaken. You too should contribute to KANSAS MEDICINE, in rural style. Write to us. You may wish to emulate this example, or you may formulate your own style. The rigors of practice allow little time or energy for organized, intense research and review. But as time permits, unfettered imagination, not bound by grant renewal deadlines, not shackled by departmental program priorities, can germinate ideas unique to private practice or rural health care. There are some fine transatlantic examples of medical inquiry on a low budget.[1] We hope this appeal and Dr. Ohmart's article will stimulate your own contribution and participation. We look forward to hearing from you.

1. Heathcote JA. Why do old men have big ears? *BMJ* 1995;311:1668.

I Practice in the Rural Wilderness

RICHARD V. OHMART, M.D., **Oakley*

I recently attended an ALSO course in Denver. For those of you not familiar with all the little devils known as acronyms (all of us?), that stands for advanced life support obstetrics. It is modeled somewhat after the more familiar ACLS and ATLS courses, sponsored by the AAFP, and designed for "rural" physicians. It is the use of the word rural that triggered a series of questions in my mind, questions not new to me and questions many of you have no doubt pondered as well. They begin with "What is rural?"

I believe I practice in a rural area, but I am not certain by whose definition. I have lived and practiced in Oakley since I completed a rotating internship in 1963. The present population of the town is about 2,200 souls, although some might maintain that the soulless in Oakley lower that count somewhat. Logan County, in its entirety, may have a population of 3,000. The surrounding counties and communities are not substantially different. We are predominantly dependent on agriculture for our livelihoods. This certainly would seem to me to be rural, or perhaps remote is a better term.

The nearest community with any supply of specialists is Hays, 90 miles to the east of us — not far by modern reckoning, but more than an evening's stroll. Yet at the Denver course, designed for rural physicians, the instructors suggested asking our OB consultants to step in and review certain problems with us. Somehow, I can't visualize one of the already overworked Hays obstetricians spending three hours driving to and from Oakley to offer his opinion — especially if that opinion might be that all was fine, and I just needed to continue what I was doing. Another suggestion was that I alert the local neonatologist if I anticipated problems with a neonate. Our "local" neonatologist is also in Hays, and I understand she will be leaving soon, meaning the nearest neonatologist will be in Denver, 250 miles west of me. Alert him or her? Indeed!

*Address correspondence to the author at New Frontiers Health Services, 123 Center, P.O. Box 756, Oakley, Kansas 67748.

These are not complaints, simply facts which are painfully obvious to those of us who have chosen to practice in such a location. I don't believe anyone who has not practiced in a similar setting has much of an idea of what medicine, or life, in such a more or less isolated community is. Certainly few CME courses, articles, etc. appear to me to show much inkling of the way I have spent my life.

Second question: Why do I stay here, or more correctly, why have I chosen to stay here through 30 odd (in all meanings of the word) years? The obvious reason is that I have always liked what I do, and that enjoyment has grown as the years have progressed. I wouldn't imply that there have not been times when I have wanted to leave. In fact, many years ago I went so far as to call the Psychiatry Department at KUMC about the possibility of a residency there. The head of the department, whose name I have now forgotten, called back the next day, asking how soon I could start. That frightened me away — for better or worse I will never know.

But to go further, why do I like my practice? I like the people of Oakley, although I assume they are little different from those of any similar community. I have come to know them, their strengths and weaknesses, and to understand many of the sources of both. I respect their wisdom and opinions, although I sometimes argue long and hard with some who are as hard-headed as I. I have delivered many of them and watched, sometimes wept, as they have grown up. I have seen others go from the strength of their forties to the frailties of their seventies. While not always fun, my practice has always been rewarding, the practice I dreamed of while in medical school.

And there is no reason why it should not be the practice of which I dreamed. During my 32 years here I have been the only physician practicing in Oakley for 10 or so years. That has given me a chance to design both my practice and the patterns at the hospital to conform to my own ideas and desires. The fact that the hospital administrator throughout almost all of my tenure has been the same man, and a good

friend, has been of immeasurable importance in all my decisions, as well. Now that there are other providers working with me (to be more thoroughly covered in the future), I have more free (even off-call) time and can relax with Carol, my wife of 38 years.

When I get away from Oakley and listen to, or converse with, others of you in Kansas and elsewhere, I realize other advantages to my situation. To date I have little contact with managed care, although there are hints and heralds of its imminent arrival. My patients see me because they choose me (Carol says it's because I was the only act in town), not because I am a panel member, or the physician their company chose. When they do call, or ask to see me, I am usually accessible, almost always in an emergency. I know that the others with whom I work provide excellent care, and I can relax knowing that I am not essential. My fantasies about that have been tamed through maturity and experience. Minor hassles, such as parking near my office, safety in the street outside the office or parking lot, and the intricacies of relationships with nurses and ancillary hospital personnel hardly exist. The people of Oakley respect me and are considerate of me and my time, as they are of the other providers with whom I work. I hope we are as considerate of them.

I do not practice in Paradise, however. There are the problems common to most medical practices: lack of time, increasing paperwork, the specter of malpractice, etc. Many of these appear to me to be less stressful here than they might be in a larger community, but I am no more qualified to comment on an urban practice than those I mentioned above are to understand my situation. The questions asked are all answered with the same basic answer: I have spent my life building a practice in Oakley, I like that practice and anticipate that I will continue to enjoy it.

And I have discovered another term for the area in which I practice. I understand that the U.S. government considers any area with a population of less than six persons per square mile as "rural wilderness." Perhaps that describes my locale, but certainly not my life.

Geriatric Ethics: Responsibilities and Conspiracies, Part I

NINA AINSLIE, M.D.,* WILLIAM BARTHOLOME, M.D.,† AND LINDA WOLTER, M.D.,‡ *Kansas City*

Case: Mr. E.F. is a 79-year-old man seen for evaluation of slowly progressing cognitive decline and personality change. His family reports memory impairment, unrealistic fears, and agitated behavior such as pacing and following his wife around the house. He and his wife live on a farm where the patient enjoys being outdoors, puttering with farm equipment, and occasionally playing golf. He still drives and has never been lost nor had an accident. When his wife leaves him alone at home, he becomes anxious and drives to town to look for her. The wife states that everyone in town knows him and looks out for him. Mr. E.F. is a lifelong gun collector with two unlocked gun cabinets containing many guns in his house.

On exam, Mr. E.F. has no focal neurological deficits. He has difficulty with naming and apraxia. He answers most questions by saying "no" or "I don't know," evading direct questions. He appears embarrassed by his deficits, but states that his family is overly concerned about his memory loss.

Mr. E.F.'s wife and daughter request that he not be told if his diagnosis is Alzheimer's disease. They fear he would become depressed and state he would be "destroyed" if he knew.

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Note: The Center on Aging sponsors a monthly discussion of the ethical issues of a geriatric case. The case is presented by a geriatric medicine fellow, and Dr. Bartholome, a pediatrician and ethicist, leads the discussion. The intent is to examine and develop an understanding of the issues involved in the case.

Discussion

One of the issues in this case is the question of the physician's responsibility to the public when a patient is potentially dangerous. Mr. E.F. is still driving and has had no accidents nor become lost — so far. However, with a progressive dementia such as Alzheimer's disease, he may already be an impaired driver and he will certainly become one. Furthermore, he has two cabinets of guns in his house, and his family fears he may become depressed about his disease.

It may be a simple matter, and not a violation of confidentiality, to advise the patient and his family to be certain all the guns are unloaded and all ammunition is inaccessible to the patient. Advising him to stop driving and suggesting that his family take away his car keys are also easy options. However, whether or not to notify the Department of Motor Vehicles is a more difficult issue.

Traditional medical ethics prohibits breaching the confidentiality of the patient. In the past 20 to 25 years, however, breaching confidentiality to protect other members of society has become more acceptable. An early court case occurred in California more than 20 years ago, when a graduate student murdered his former lover. The psychologists who knew of the student's homicidal ideation were sued by the murdered woman's family for failing to warn her of the danger.

More recently, the question of the duty to warn sexual or drug-sharing partners of a person with HIV infection has arisen. Some states, such as Missouri, have stated that a doctor has a legally enforceable duty to warn contacts. Kansas courts, on the other hand, have straddled a finer line. In this state, a physician is not obligated to warn contacts of a patient who refuses to do so, but the doctor is not breaching confidentiality if he or she chooses to notify contacts.

A third situation in which courts have been

(Continued on page 15.)

Prevention of Hepatitis A

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Hepatitis A could follow smallpox into history as an extinct virus. We now have the ability to protect the only reservoir, humans, from infection through vaccination. Last year, a highly effective vaccine that could immunize enough people to interrupt forever the cycle of transmission was introduced into the United States.

Licensed in the U.S. in the spring of 1995, an inactivated vaccine containing alum-adsorbed, formalin-inactivated hepatitis A virus grown in human diploid fibroblasts produced a 90-94% protective titre after a single dose and 99% after a booster dose at one year.[1,2]

Unlike smallpox, hepatitis A infection is often asymptomatic, and those infections that are symptomatic are infrequently complicated by autoimmune disease.[3] This disease is not perceived by the public to be a major health threat. Furthermore, the cost of the vaccine is about $50 per dose, and with two doses recommended for full protection for adults and three for children, hepatitis A may remain a threat for years to come.

Vaccinating Those at Risk

Attention should be focused on those at highest risk of acquiring the illness or of spreading it to others should they become infected. Specifically targeted are travelers to areas with poor sanitation and people who are occupationally exposed. Travelers to any part of Africa, Asia, eastern Europe and the Americas south of the United States are at greatest risk. Anyone traveling to these areas for more than an insulated business excursion should be vaccinated. The risk of the average American traveling to endemic zones has been estimated at three cases per thousand visitors per month.[4] If less than four weeks remain before departure, 0.02 mL/Kg of immune serum globulin should be administered simultaneously in another extremity. The second dose of vaccine, while recommended, is not required unless the traveler will be returning to a high-risk area in the future.[5]

Three occupational groups are at very high risk of hepatitis A: child care workers, health care workers providing for institutionalized patients, and food handlers.[6] Other groups at risk include sewage treatment workers, homosexual men, and intravenous drug users. Child care workers who deal with infants in diapers are at risk, since children under age 1 with hepatitis A are rarely symptomatic. A single infected infant may fecally inoculate a child-care center and from there the disease may spread into the community. Similar risks abound with institutionalized patients.

Food handlers, particularly those who prepare salads, desserts and items that are not cooked, have been the source for large outbreaks of hepatitis A. In Denver nearly 3,500 people were exposed by a single catering operation between Thanksgiving and Christmas of 1993, and in Kansas City over 2,000 people were exposed to infection at a restaurant salad bar in 1995 (author's personal clinical practice). The latter coincided with an acute shortage of immune serum globulin because of a national recall due to possible contamination. The liability of the employer in these cases makes it desirable to minimize risk by immunizing the most critical personnel.

Screen or Vaccinate?

Since hepatitis A is a sporadic infection in the United States, many people are already immune. The national average is 40% with higher rates among older cohorts and those of lower socioeconomic status. The highest rates, often approaching 100%, are seen in older native Americans living on reservations.[7] Younger people just entering the work place fall in the 15-26% range, while children have a prior infection rate of less than 10%.[8]

The significant prevalence of prior hepatitis A infection in our population complicates public vaccination policy. Does one screen for immunity prior to vaccinating, or immunize everyone

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without screening? A central city hospital in the Kansas City area began to screen its food handlers prior to immunization. Most of the employees were minorities (85%) and female (65%), and all were lower socioeconomic status. Out of 92 individuals, 33 (36%) had positive IgG titres for hepatitis A.

It cost the hospital $15 to obtain an IgG titre and $100 to vaccinate each non-immune employee. This means that to identify and vaccinate two non-immune people at a cost of $200, three were screened at $45. The total costs were $245 for screening and selective vaccination, compared with spending $300 for vaccination without screening. Therefore, it seems reasonable to screen high-risk travelers and workers for antibodies to hepatitis A, then vaccinate only those without protective titres.

Even if fully applied, this policy would likely not eradicate hepatitis A. A superior policy, such as is currently applied to hepatitis B, would be routine, universal vaccination of infants. Until then, we can expect to continue to see patients with this preventable disease.

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YOUR OLDER PATIENT

(Continued from page 13.)

lenient about breaching patient confidentiality has been in physician reporting of drug use by persons, such as airline pilots, whose actions or impairments can have significant effects on public safety.

Optimally for patients such as Mr. E.F., the family will take action to prevent the patient from driving. For family members who are in denial about their loved one's impairments or who lack the fortitude to take action, the physician may have the responsibility to protect both the patient and the public by reporting the patient's impairment to the Department of Motor Vehicles.

A second issue arising in this case is that of withholding information about the diagnosis from the patient. This issue will be discussed in "Responsibilities and Conspiracies, Part II."

SUGGESTED READING

Odenheimer GL, Beaudet M, Jette AM, et al. Performance-based driving evaluation of the elderly driver: safety, reliability, and validity. *J Gerontol: Med Sci* 1994;49(4):M153-M159.

CLASSIFIED ADVERTISEMENTS

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SCIENTIFIC ARTICLE

Complications of Intravenous Heparin Therapy for Treatment of Thromboembolic Disease in Joint Arthroplasty Patients

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Thromboembolic disease is a serious problem in both hip and knee arthroplasties. The incidence of deep vein thrombosis has been estimated at 300,000 to 600,000 cases per year in the U.S. with 50,000 deaths from pulmonary embolism. There are numerous reports on this subject in the literature on orthopedic patients. In 1991, Anderson[1] conducted a survey and found only 19% of physicians at community-based hospitals were using some sort of prophylaxis against thromboembolic disease in patients undergoing total joint arthroplasties. In teaching hospitals, 44% of the physicians used prophylaxis. Paiement,[2] surveying 5,000 orthopedists in 1994, indicated that some type of prophylaxis was used by 84% of the surgeons. A variety of prophylactic treatments have been used, consisting of low-dose warfarin, low-molecular-weight dextran, low-dose heparin therapy, adjusted-dose heparin therapy and the use of external pneumatic compression devices and thigh-high elastic stockings, as well as aspirin. Harrison[3] compiled data on the effectiveness of various antithrombotic therapies in patients undergoing hip surgery. He did not show any statistically different reduction in the incidence of thromboembolic disease, as defined by venography, resulting from any particular one of the therapies.

Thromboembolic disease is asymptomatic in the vast majority of patients undergoing joint arthroplasty. The purpose of this study was to delineate the incidence of the development of thromboembolic disease and the complications of treatment in patients undergoing total hip arthroplasty, total knee arthroplasty and endoprosthesis with fractures of the femoral neck at a Wichita hospital.

Materials and Methods

The medical records of all patients undergoing total hip arthroplasty, total knee arthroplasty and hemiarthroplasty for fractures of the femoral neck at Wesley Medical Center between January 1, 1991 and December 31, 1993 were reviewed. There were 1,225 cases, including 699 total knee arthroplasties. Of these, 21 were primary bilateral total knee replacements, 57 were revision total knee arthroplasties, and 621 were unilateral primary total knee replacements. These patients had an average age of 69.4 years, with a range of 27 to 93 years. There were 331 total hip arthroplasties. Of these, 83 were total hip revision arthroplasties, and the rest were primary total hip arthroplasties. These patients had an average age of 67.5 years, with a range of 21 to 89 years. There were 225 patients with hemiarthroplasty done for fractures of the femoral neck. These had an average age of 80.6 years, with a range of 51 to 101 years.

All cases were reviewed for complication of thromboembolic disease, either deep vein thrombosis or pulmonary embolism. The incidence of prophylactic treatment for the prevention of thromboembolic disease was reviewed. The rate was 92% for the total hip patients, 94% for the total knee patients, and 22% for the hemiarthroplasty patients. Multiple regimens of treatment for prophylaxis of deep vein thrombosis were used. These consisted of thigh-high elastic stockings, segmental pneumatic compression stockings, subcutaneous heparin, aspirin, low-dose warfarin therapy, and low-molecular-weight dextran. Various combinations of these were used. The majority of patients were treated with low-dose heparin therapy in combination with aspirin plus elastic stockings, or low-dose warfarin in combination with elastic stockings or external pneumatic compression stockings.

The diagnosis of pulmonary embolism or deep vein thrombosis was made in 1.7% of the patients. There were 13 cases (1%) with pulmonary embolism (1%) and eight cases (6%) of deep vein thrombosis.

Diagnosis was made on the basis of clinical presentation, laboratory workup (blood gases, EKG) and were confirmed either by Doppler or venograms for deep vein thrombosis and pulmonary ventilation perfusion scans or pulmonary angiography.

One patient who underwent a total hip arthroplasty died two weeks following discharge from

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TABLE 1. Complications

Diagnosis Operator	Case Synopsis	Complication	IV Heparin Started
Osteoarthritis Hip THA	Developed a PE started on IV Heparin	Developed a large right hematoma required transfusion 5 units packed RBCs. Had fatal MI on 14th hospital day.	POD #2
Femoral neck fracture endoprosthesis	Developed PE Preop, anticoagulated prior to OR. Stopped for surgery then restarted.	Developed hip hematoma, blood anemia requiring 5 units of packed RBCs, LOS 28 days.	1st Hospital Day
Osteoarthritis Knee TKA	Developed DVT 3rd Postop Day	Bleeding requiring 1 unit autologous blood, 4 units packed RBCs. Developed peroneal compression neuropathy.	POD #3
Osteoarthritis Hip THA	PE 5th PO Day	Required 2 units packed RBCs prior to PE. GI bleed after starting IV Heparin requiring 4 units packed RBCs.	POD #4
Femoral neck fracture endoprosthesis	DVT Venous Doppler positive to DVT femoral vein	Excessive wound bleeding. Transfused 2 units blood & 2 units fresh frozen plasma. Developed wound infection requiring additional surgery. LOS 51 days.	POD #3
Osteoarthritis Hip THA	PE 4th PO Day	Wound hematoma with sciatic compressive neuropathy drained, required 1 unit packed RBCs. Sciatic nerve injury did not recover.	POD #4
Osteoarthritis Hip THR	Suspected PE 3rd Postop Day	Wound hematoma with sciatic nerve palsy, surgical drainage of hematoma with recovery of sciatic function.	POD #3

the hospital. Pulmonary embolism was suspected, but a postmortem was not obtained. This is not included in the cases of pulmonary embolism.

All patients with pulmonary embolism or deep vein thrombosis were treated with intravenous therapy with the exception of one. This was a case of deep vein thrombosis that was treated with warfarin only, as the patient had been started on warfarin therapy and was anticoagulated at the time of diagnosis. There was one additional patient who developed chest pain on the third postoperative day. A lung scan was performed and was interpreted as having intermediate probability for pulmonary embolism. The patient was started on intravenous therapy. The following morning, the patient developed a large hematoma about the hip and a sciatic nerve palsy. The heparin was discontinued. A pulmonary angiogram done at that time did not show evidence of pulmonary embolism. The patient was subsequently taken to surgery and the hematoma drained, resulting in full recovery of the sciatic nerve function.

Twenty-one patients were treated with intravenous heparin therapy for either pulmonary embolism or deep vein thrombosis. Seven of these cases had significant complications related to increased bleeding at the operative site. There were hematomas requiring multiple transfusions, nerve compression syndromes secondary to hematoma, infection of the hematoma causing additional surgery and gastrointestinal bleeding (see Table 1).

Discussion

We were not able to demonstrate that any particular treatment was more effective than the other. However, 50% of the total hip arthroplasty patients who developed pulmonary embolism or deep vein thrombosis had no prophylactic treatment, and 75% of the hemiarthroplasty patients who developed problems with pulmonary embolism or deep vein thrombosis had no prophylactic treatment.

All cases of complications occurred when the heparin was started on the fourth postoperative day or sooner. Of the 21 patients treated with

intravenous therapy, eight were started on the fourth postoperative day or sooner. In six of these eight cases (75%), significant complications occurred. The study shows that patients with arthroplasty procedures of the lower extremity who are started on intravenous heparin therapy in the early postoperative period are prone to significant complications, and this is a treatment that should be used cautiously and only with a definitive diagnosis.

The findings of this case correspond to other reports in the literature, specifically Patterson, et al.[4] They reported an overall incidence of bleeding complications of 25%, and this was related to the time that elapsed between arthroplasty and the administration of heparin therapy. In patients in whom bleeding occurred at the postoperative site, treatment was started on an average of 5.9 days postoperatively. In patients who had no bleeding problems at the operative site, treatment was started on an average of 11 days postoperatively.

The overall incidence of thromboembolic disease appears to be quite low in this study. If this is specifically looked for using studies such as duplex ultrasonography or venograms, it has been shown to be as high as 20-50% in patients undergoing elective joint arthroplasty of the lower extremity. Cases of deep vein thrombosis or pulmonary emboli in this study were all symptomatic. Since our overall incidence of symptomatic thromboembolic disease was extremely low, the methods of prophylactic treatment are probably effective in reducing the incidence of thromboembolic disease. This study did include all the patients who were readmitted to Wesley Medical Center, but it is possible that some patients may have been admitted to other hospitals for treatment of thromboembolic disease that occurred later and were not picked up in this study.

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SCIENTIFIC ARTICLE

The Provision of Labor and Delivery Services by Graduates of Four Kansas Family Practice Residencies

ANDREW M. BARCLAY, M.D.,* DEANNA PARKER KNAPP, M.A.,† AND KEN J. KALLAIL, Ph.D.,* *Wichita*

Abstract: The provision of labor and delivery services by family physicians is especially important in largely rural states such as Kansas. The decline in the number of family physicians offering labor and delivery services threatens those who depend on access to primary health care in rural areas. A survey was mailed to all 370 of the University of Kansas School of Medicine-Wichita (UKSM-W) family practice residency graduates. Two hundred sixty-five (72%) graduates responded, of whom 206 are in private practice. Eighty percent of responding graduates practice in communities of less than 100,000, and 72% of those physicians provide labor and delivery services. Although 48 of 206 graduates have ceased delivering babies, 131 still do so, averaging 41 deliveries per year. Sixty-five graduates perform C-sections, averaging 12 per year. Conclusions: UKSM-W graduates afford rural patients considerable access to care. Income, work hours, and practice satisfaction were similar in all three groups (no delivery, delivery without cesarean section, and cesarean section). Policy makers are justified in expanding educational programs in family practice that emphasize complete care of the pregnant woman.

Introduction

Fewer residency-trained family physicians are providing complete pregnancy care in the U.S. today.[1-4] In the Family Practice News study,[5] only 21% of the 1991 family practice respondents delivered babies, compared to 33% in 1986. Only 34% of family physicians in rural areas delivered in 1991, down from 50% in 1986.[5] The survey also showed that only 16% of obstetricians practice in rural areas, which confirms the critical need for rural family physicians who deliver babies.

In America's heartland, the majority of family physicians deliver babies. Sixty percent of residency-trained family physicians in the American Academy of Family Physicians' West North Central Division still do.[4] Further, 8.5% of that group performs cesarean sections.[4]

Rosenfeld[6] reported that only 55 of 126 responding family physicians in rural Tennessee had ever provided pregnancy care, and only 10% were still delivering babies. Only 43% of her respondents, however, were residency-trained, and most were in solo practice. Only 5% had cesarean section privileges.

Several studies provide evidence that a reduction in family physicians who deliver babies leads to poor access to care and increased perinatal mortality. Nesbitt and colleagues[7] found increased rates of complicated deliveries, prematurity and higher neonatal costs for women in rural communities with fewer doctors who deliver. Women in rural Arizona who received less prenatal care had higher infant mortality rates[2] than their urban counterparts. Further, a negative correlation between physician availability and infant mortality was found in Indiana's nonmetropolitan counties.[8]

Since the UKSM-W Family Practice Program at Wesley Medical Center graduated its first class in 1971, graduate education in family practice has expanded to four programs graduating 27 per year. There is considerable emphasis on training in prenatal care, labor, and delivery. All the full-time family practice residency faculty deliver babies and staff residents in the delivery room.

The following questions were posed regarding the residency graduates. What labor and delivery services are provided by UKSM-W fam-

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TABLE 1. DELIVERY DATA FOR GRADUATES BY COMMUNITY SIZE						
Community Size	Total Number of Physicians		Number of Physicians: No Deliveries	Number of Physicians: Deliveries/ No C-Section	Number of Physicians: Deliveries/ C-Section	Percent of Physicians: Total Deliveries
	no.	%	#	#	#	%
<5,000	58	29%	13	17	28	78%
5,000-10,000	31	15%	7	10	14	77%
10,000-25,000	30	15%	10	8	12	67%
25,000-100,000	42	21%	15	23	4	64%
>100,000	42	21%	29	8	5	31%
Total*	203	100%	74	66	63	64%

*n=203 (3 physicians did not indicate community size)

ily practice residency graduates? How do labor and delivery services vary according to community size, satisfaction with practice, income, and other practice variables? The answers to these questions provide direction for family practice education, allow for better understanding of the decline in the number of family physicians delivering babies, and contribute to new strategies for improving access to rural health care.

Method

To obtain pertinent data about pregnancy care, a questionnaire was mailed in 1992 to all 370 UKSM-W family practice residency graduates from the HCA/Wesley Medical Center (a 6/6/6 program with 146 graduates), St. Joseph Medical Center (a 9/9/9 program with 118 graduates), and St. Francis Regional Medical Center (an 8/8/8 program with 73 graduates) in Wichita, and the Smoky Hill (a 4/4/4 program with 33 graduates) in Salina. A follow-up mailing was sent one month later to non-respondents. Many of the items in the UKSM-W Family Practice Residency Graduate Questionnaire were comparable to the survey used by the University of Iowa, Office of Community-Based Programs. This Iowa survey has obtained data on family practice residency graduates for 20 years. The questionnaire presented 28 items regarding the graduates' demographics, residency education and medical practice characteristics. Specific questions were asked about practice and procedures related to reproduction, practice arrangement, gross and net income, practice problems, hospital privileges,

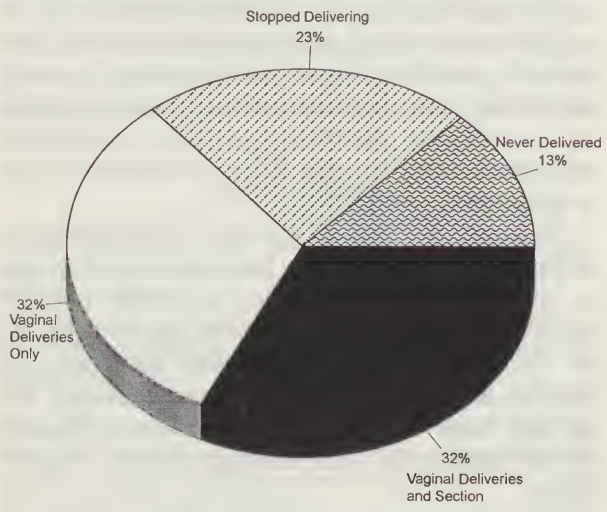

Figure 1. UKSM-W family practice graduates delivering babies.

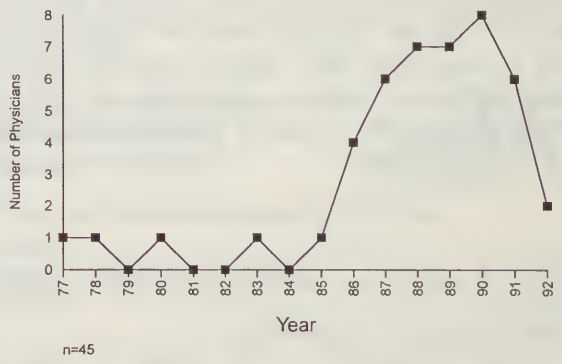

Figure 2. Number of physicians who ceased delivering babies, by year of cessation, 1977-1992.

TABLE 2. NUMBER OF GRADUATES PERFORMING PROCEDURES RELATED TO REPRODUCTION (n=202)*

# *Graduates*	%	*Procedure*
139	68%	Endometrial biopsy
124	61%	D & C
114	56%	Vasectomy
83	41%	Cervical biopsy
62	30%	Colposcopy
49	24%	Tubal ligation
22	10%	IUD
15	7%	OB ultrasound
9	4%	Hysterectomy
8	3%	Exploratory laparotomy

*four respondents did not respond to this item

and career satisfaction. Questionnaires were returned directly to the graduate's residency program. Data analysis was completed using the SPSS statistical package.[9] Statistical significance was calculated using chi square and t-test analyses, as appropriate.

Results

Distribution. Of the 370 graduates, 265 responded (72% response rate). For the purposes of this study, the analysis was limited to the 206 (56%) respondents in full-time private practice. Fifty-six percent of the respondents practice in Kansas, and 24% practice in the surrounding states of Nebraska, Colorado, Oklahoma, and Missouri. The mean age of respondents was 38 years (SD = 5.4; range 29-55). Participation in solo (23%), family practice groups (56%), and multispecialty groups (19%) by the graduates was comparable to national data. The geographic distribution of respondents was similar to that of non-respondents.

Table 1 displays the percentage of physicians per community size. The majority of graduates currently practice in communities of less than 25,000. Eighty percent of graduates practice in communities smaller than 100,000. Half have less than a total of seven physician colleagues in their communities.

Pregnancy care. Sixty-four percent of the 206 respondents (Figure 1) delivered babies, with a mean of 41 deliveries per year. Thirty-two percent perform C-sections, with a mean of 12 per year. Table 1 shows that 78% of the group of UKSM-W family practice graduates in towns of less than 5,000 population delivered babies. Only 48 graduates (23%) have ceased delivering babies (Figures 1 & 2). Of those who started practice delivering babies, 73% are still doing so; moreover, the cessation rate has slowed in the last two years. The graduates, in addition, perform a wide variety of procedures related to reproduction (Table 2).

The percentage of graduates delivering babies within and outside of Kansas is identical.

Satisfaction. Of those in practice, 87% are satisfied with the practice. No statistically significant difference was seen between satisfaction expressed by graduates delivering babies compared to those not delivering babies.

Preparation and work activities. Ninety-seven percent reported they were well prepared for practice, including labor and delivery, and 90% are pleased with the choice of family practice as a career. Seventy-one percent teach residents and medical students. Work hours are slightly higher for physicians who perform cesarean sections (Table 3), and those physicians tended to see

TABLE 3. WORKING HOURS, PATIENTS SEEN AND LIABILITY COSTS OF FAMILY PRACTICE GRADUATES

	Office Hours	Hospital Hours	ER Hours	Other Hours	Total Pts/Day	Medical Liability Insurance Annual Cost
No Deliveries	39	7	5.7	2.4	33.3	$6,451
Deliveries/No C-section	39	9	5.0	2.2	27.0	$10,279
Deliveries/C-section	38	11	5.2	2.2	39.6	$11,731
Mean all graduates*	39	9	5.7	2.4	36.7	$9,645

*only 163 reported insurance costs

more patients, although these differences were not statistically significant.

Income. The income range gross ($250,000-$300,000) and net ($90,000-$100,000) were identical for all three groups (those not delivering babies, those delivering babies without cesarean section and those performing cesarean section). Only three physicians out of 206 indicated that financial concerns are a major source of dissatisfaction. The mean medical liability costs were $3,828 more for physicians performing cesarean sections than for those who do not deliver babies. Graduates delivering babies in Kansas pay a mean of $12,392 for medical liability coverage, compared to graduates elsewhere, who pay $9,224 ($t = 1.83$, $p < .05$).

Discussion

UKSM-W residency programs produce graduates who deliver more babies than other family practice graduates because they are more rural than the national average, and there is a local emphasis on providing total pregnancy care training. All residents in UKSM-W programs take a minimum of four months curriculum in prenatal care, labor and delivery, and gynecology. Additional electives are encouraged, and residents often deliver more than 100 babies by the end of their residency. All UKSM-W residency faculty deliver babies. Many of the graduates practice in communities which have a modest number of physicians and where it is unusual to have an obstetrician. Family physicians practicing in smaller communities are more likely to deliver babies. More of the residencies' graduates deliver babies, and many more perform cesarean sections than the national average. The cost of medical liability insurance for UKSM-W family practice graduates who deliver babies is approximately $4,000 per year higher than the national average. This factor should not prevent family physicians from delivering babies either in Kansas or in the region.

Kansas survived a serious medical liability problem with such high insurance rates that graduates were discouraged from delivering babies in this state. Since 1988, the medical liability insurance rates in Kansas have diminished up to 25% and may be responsible for the reduction in the number of our graduates who stopped performing cesarean deliveries. Despite paying $3,000 per year more for medical liability insurance than colleagues in other states, the percentage of graduates who stayed in Kansas performing deliveries is the same as graduates who left the state. The relative prevalence of family physicians delivering babies in rural Kansas is a factor in maintaining access to care. In Indiana, limiting access to care has been linked to higher perinatal mortality.[8]

During 1970-91, an average of two residency graduates per year stopped delivering babies. Those who did so have been replaced by more recent graduates. The data do not include older non-residency-trained physicians who may have been more likely to have stopped delivering babies during that time period.

The national attrition of family practice graduates delivering babies has been most dramatically identified by Gaskins, et al.[10] in Tuscaloosa, Alabama. Similar pressures exist in both states, although community expectations may be higher in Kansas and distance to larger communities greater.

A recent survey by Family Practice News[11] suggested a national dissatisfaction of family practice graduates with their practice life. This dissatisfaction was not reflected in the study data, nor do the data reflect a discrepancy in satisfaction between the graduates who deliver babies and those who do not. Delivering babies has been demonstrated to lead to a younger practice with more procedures related to the reproductive system.[12] Bredfeldt and Sutherland[12] found that family physicians performing cesarean sections actually had a lower income than their colleagues. Our data did not support that conclusion.

In summary, the family practice residencies associated with UKSM-W are providing graduates of high quality who are satisfied with their practice of medicine. Sixty-four percent continue to deliver babies, and one-half of these graduates continue to perform cesarean sections in communities where those services are essential. The emphasis on training in the care of pregnant women at the UKSM-W programs is successful and should continue. The reproductive services provided by graduates enhance access to care in this rural state.

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SCIENTIFIC ARTICLE

Testicular Seminoma: Review and Experience in Northwest Kansas

BABU PRASAD, M.D.,* *Hays*

Seminomas of the testes are of germ cell origin. Seminoma is the most common malignancy in men between 20 and 35 years of age. Seminoma is also the most common testicular tumor.

Men with cryptorchidism have an increased risk of developing testicular cancer, which is about 35 times that of the normal frequency. The incidence of testicular cancer is 3.8 per 100,000 males in the United States. North American whites, Scandinavians and other western Europeans have the highest rates, with the highest incidence in Denmark: 6.7 per 100,000 males. The lowest rates occur in Asians, Africans and North American blacks.

Seminomas have a distinct natural history and a treatment radically different from non-seminomas. There are basically three histologic subtypes of seminomas: classical, spermatocytic and anaplastic. Classical seminoma is the most common histologic variety seen. Ten percent are spermatocytic. These are less aggressive and are generally seen among older patients. Anaplastic seminomas constitute only 5% of all cases, and these tumors have increased mitotic activity. The histologic subtype has no prognostic importance. In clinical presentations, the usual presenting symptom is a painless mass, although pain, heaviness and tenderness are not uncommon.

Diagnostic Workup

A complete history should be taken, including information about previous inguinal or scrotal surgery, undescended testes, orchiopexy, etc. Physical examination can usually distinguish testicular masses from those involving neighboring structures such as epididymis. Testicular ultrasound is useful in differentiating solid masses from cystic lesions. When a testicular tumor is suspected, diagnosis should be confirmed by histologic examination of the tumor. Current thinking discourages scrotal biopsy. The appropriate surgical procedure is a radical orchiectomy through an inguinal incision. The laboratory studies should include CBC, chemistry, serum HCG, alpha-fetoprotein, placental alkaline phosphatase levels, etc. The radiographic studies should include a chest x-ray and CAT scans of the pelvis and abdomen. Lymphangiography can also provide very useful information. The most widely used staging system for classifying testicular seminoma is shown in Table 1.

The treatment should consist of high inguinal orchiectomy. Adjuvant irradiation to retroperitoneal nodes is always administered post-operatively. Patterns of care studies have indicated that doses as low as 2,500 cGy may be effective in an adjuvant setting. Platinum-based chemotherapy is used in patients with advanced disease.

Experience at Hays Medical Center

We have reviewed our experience at Hays Medical Center with patients who have testicular seminoma. There were 19 referrals to the Radiation Oncology Department between 1978 and 1991. The age distribution of these patients is shown in Table 2.

Two patients had anaplastic seminoma. In our series, spermatocytic seminoma was not found. The rest were classical seminomas. Only three patients presented with testicular discomfort or heaviness. Sixteen of the 19 patients were in

TABLE 1. STAGES OF TESTICULAR SEMINOMA

Stage I	Disease limited to testes.
Stage II	Involvement of infradiaphragmatic nodes.
Stage III	Involvement of supradiaphragmatic nodes.
Stage IV	Extralymphatic disease.

*Radiation oncologist, Hays Medical Center

Address correspondence to the author at 2220 Canterbury Drive, P.O. Box 8100, Hays, Kansas 67601.

TABLE 2.
AGES OF PATIENTS TREATED AT
HAYS MEDICAL CENTER

Age	*Number of Patients*
< 30 years	9
30 to 45 years	8
> 45 years	2

Stage I. Three patients had Stage II disease. In our series, only one patient had prior scrotal biopsy.

Sixteen patients received irradiation to bilateral para-aortic nodes and ipsilateral pelvic lymph nodes ranging from 2,500 cGy to 3,000 cGy. One patient received 2,040 cGy in 17 fractions to the whole abdomen due to massive intra-abdominal disease. Three patients with Stage II disease also received prophylactic mediastinal irradiation to 2,000 cGy.

Sixteen percent experienced nausea requiring antiemetics. Thirteen had some level of leukopenia. Three patients had diarrhea and were placed on a low-residue diet and Lomotil prn. Two patients experienced thrombocytopenia. One patient had mild esophagitis. None of the patients had life-threatening bone-marrow suppression or any other complication.

All 19 patients are living free of disease with follow-up ranging from three to 11 years.

Conclusion

In summary, patients with early-stage seminomas are highly curable with orchiectomy followed by irradiation. Patients with advanced disease are generally treated with chemotherapy following surgery, also with excellent results.

Epistles of Dr. Karl

The Selected Correspondence of Karl A. Menninger, 1919-1945, edited with an introduction by Howard J. Faulkner and Virginia D. Pruitt (University of Missouri Press, Columbia, 1995; first published by Yale University Press in 1988), 451 pp.

The Selected Correspondence of Karl A. Menninger, 1946-1965, edited with an introduction by Howard J. Faulkner and Virginia D. Pruitt (University of Missouri Press, Columbia, 1995), 278 pp.

As a medical student in Canada, I saw the 1962 CBS documentary on the progressive management of mental illness at the Menninger Foundation in Topeka and wondered if I would be too late to sit at the feet of Drs. Karl and Will following my graduation. It turned out I was able to, and it shaped my life in a way I could not have imagined. Perhaps this is a measure of how compelling these two brothers were in persuading the country to regard psychiatry as both a humane and a scientific endeavor worthy of support for a national effort to improve the care of its mentally ill.

As his students at the Menninger School of Psychiatry, we related to the charismatic public persona of Dr. Karl and held him in enough awe to avoid much discussion about the private Karl Menninger. This collection of letters also makes little reference to the problems beneath the surface, even though the editors added background in their introductions to each section. It is necessary to look to other sources for more information about his private life, including notably *Menninger: The Family and the Clinic,* by Lawrence J. Friedman, published in 1992.

The letters are published in two volumes and include correspondence received by Menninger to which he is responding. He was a prodigious letter-writer, stating in 1939 he estimated he wrote 80 letters a week. The 10 letters with a 1939 date, for example, represent only a minute proportion of his total correspondence. The first volume was initially published in 1988, when Menninger was still living, and he took the liberty of excluding a number from the original selection, as well as excising portions from "perhaps a dozen others." This was after the authors, who lived in Topeka and probably were wary of incurring Dr. Karl's wrath, had presented him with their final selection. This first volume therefore does not contain some of his more unguarded comments, which might have revealed more of what has been reported by other informants.

The initial letters show a preoccupation, as one would expect, with establishing himself as a psychiatric practitioner in Topeka who also devoted considerable energy to making contact with leaders in the field from all over the country. Initially he was cool toward psychoanalysis, like his mentor and teacher in Boston, Ernest Southard. Southard's sudden death in 1919 interrupted their close relationship, and he was exposed to psychoanalytic ideas with which he became quite intrigued, even "infatuated," as he put it. Though he experimented with psychoanalytic techniques, he did not undertake the first of his two brief personal analyses until 10 years later, in 1930. His reaction to his only contact with Sigmund Freud in 1934 reveals much about Menninger and his attitude toward psychoanalysis. He was deeply hurt by Freud's apparent disinterest, but refrained from being critical and remained loyal. Later he worked very hard to get Freud's daughter, Anna, to come to Topeka. Though he did not succeed in getting her to accept a position at Menninger, she did on more than one occasion come as a visiting lecturer.

Much of the correspondence in the middle part of Dr. Karl's career deals with his aggressive efforts to define psychoanalysis within American psychiatry. He relentlessly attacked those who strayed from the orthodox position and attempted to redefine the field in their own way, accusing them of disloyalty. There are also numerous contentious letters in which he criticized colleagues with whom he was on generally friendly terms, frequently because he believed he himself had been slighted or misrepresented by them. Menninger's belligerent responses to some of his

critics alternated with elaborate efforts to explain to and appease those who showed deference to him. His correspondence poses the obvious question about the extent to which his theoretical formulations were predisposed by his psychological makeup, rather than the "scientific" investigation to which he frequently made reference. Of course the same can be said about the other psychoanalysts of his time, who were riding the crest of a heady new ideology which they were confident could significantly modify human behavior for the good, just as technological advances were changing the way people lived and greatly enhancing their material standard of living. The human resistance to change even in the face of enlightenment was troubling to Dr. Karl, just as it was to others. It led Freud to speak of death instinct, upon which Menninger elaborated in his book *Man Against Himself* in 1938.

The long-standing conflict with his wife came to a head with his divorce in 1941, but only one letter mentions this, and then only in passing after he was remarried. We are left to reading between the lines in his correspondence to Karen Horney, his wife's analyst, and his later relentless attacks against Horney in other correspondence. When his former analyst Franz Alexander pointed out the need to differentiate between "personal issues and objective statements," Menninger dismissed him out of hand.

By the end of the period covered in the first volume, he was 48 years old and established as a leading figure in American psychiatry, and together with his brother and father, recognized as heading the foremost psychiatric treatment center in the country.

The second volume covers the next 20 years, the pinnacle years of the Menninger establishment, which now became the Menninger Foundation — though not without considerable reservations about possible loss of control entailed in this change. As it turned out, the issue of control was fought out within the family itself, between Karl and Will. After a threatened resignation by key figures within the Foundation, Dr. Will took control and was supported by the trustees. Karl reacted to this in a petulant but ineffectual manner, dramatically writing on his April 21, 1965 calendar page the words, "the day Karl Menninger was assassinated!" This was the culmination of a long and difficult, though muted, struggle between him and Will. But the correspondence in the second volume gives no hint of this problem, with the exception of the final letter, dated October 3, written by his brother Edwin, who lived in Florida, but participated in the deliberations of the Foundation as a trustee. This remarkable letter from a non-psychiatrist to his nationally famous brother, already in his late sixties, chides him as one would a child for his manifest selfishness and fearfulness, and then is signed "affectionately."

Karl Menninger dramatically illustrated by his life the stereotype of the psychiatrist who remains a prisoner of his own complexes. Yet this man was enormously influential in popularizing psychiatry and destigmatizing mental illness. Throughout these two volumes, there are numerous examples of his forceful defense of groups which society scapegoats, namely the mentally ill and other feared and unpopular minorities within American society. The extraordinary development in Topeka of the most prestigious psychiatric clinic in the country, along with a training program preparing 15% of the nation's psychiatrists after World War II certainly attests to a remarkable family dynamic among the Menningers. The availability of these letters adds something to our understanding of this phenomenon, but many readers are likely to find them disappointing because of how little they tell us.

George Dyck, M.D.

Funny or Tragic?

Whether an incident is funny or tragic often depends on the viewpoint. Here is a case. I received a call from a doctor in a neighboring town. He had a patient, a young lady afflicted with a serious heart disease. Would I come? I would. It was a rainy day and the road was a sea of mud. I drove my horse until he became exhausted. Then I importuned a farmer to take me the rest of the way. His outfit was a farm wagon and a very sophisticated span of mules. When I arrived at the house, the family doctor was waiting for me. The patient had been employed in a neighboring town. Previously always in the best of health, she had suddenly been taken seriously ill. The symptoms were very confusing to the doctor. Rapid respiration was all he could see and he concluded the trouble was a weak heart. I saw a fine plump girl with pink cheeks. She had been weeping. Her pulse was slower than mine and as regular. Knowing the disposition of the doctor, I asked him and the family to let me talk to the patient alone. It was a risk but necessary. I sat down on the edge of the bed and talked to her like a child, for she was only a child, though nineteen years old. "Now tell me," I began, "now tell me just what happened to him." She burst out weeping. "I don't know," she sobbed. "He just up and married another girl." I inquired in detail all about him, his appearance, his occupation, and all that. No occupation, very handsome, with brown curly hair. I evaluated him in my own way. Handsome men, I volunteered, live off either the earnings of their wives or of their fathers-in-law. The commercial value of curly brown hair, figured in terms of buckwheat cakes, I opined was not very high.

I talked to her at length, on how fortunate she was that fate had intervened for her. Mere child, fine figure of a girl, beautiful face, young, she had no need to grieve. In calling a young girl beautiful one runs no risk of offending. One may take a cue from the newspapers. Every female that gets into devilment, if under seventy years of age, is referred to as "attractive." This I presume is following the usual newspaper habit of giving the people what they want: to wit, bunk. I explained to her that fate had much better things in store for her. I administered this sort of talk for a while and finally her face began to relax, just as that of a nine-month-old baby does when she is about to reach out her arms to you. I wrapped a blanket about her and said, "Let's go out and tell Mother you are all right." She tripped lightly out of the bedroom, through the living room and into the kitchen where the family doctor and the family were talking. The mother's look as she beheld her smiling daughter walking for the first time in weeks was something you do not see in books. "She will be all right," I assured the doctor. Then I sought the farmer and his mules and made the trip home; elapsed time, fourteen hours for the round trip. Now is this tale funny or is it tragic?

In the same community, some years later, I received a call from the same doctor. A girl was in terrible condition. She worked in a neighboring town and had come home sick, with a high fever and in terrible pain. That sounded suspicious but I could learn nothing further from the doctor. Mud as usual, and the team walked every foot of the way. Time, seven hours. The doctor was waiting for me. He announced that since calling me, the patient had become much better and was now quietly sleeping. She had an abscess where no lady ever has an abscess. The abscess had burst of its own accord and the patient was at once relieved. There was nothing to do professionally but I did make some remarks of a general nature. I had read during the trip out; I was too mad to read on the way back. I made uncomplimentary remarks, with special reference to professional incompetency and the general cussedness of humanity, all the way back. Twice seven hours. Of course, having done nothing I was entitled to no pay. But then that family never paid anything anyway, so there was no occasion to make a concrete application of this remark. Five dollars for the team and fourteen hours on the road was all I was out. Personally, I never could detect any humor in this incident.

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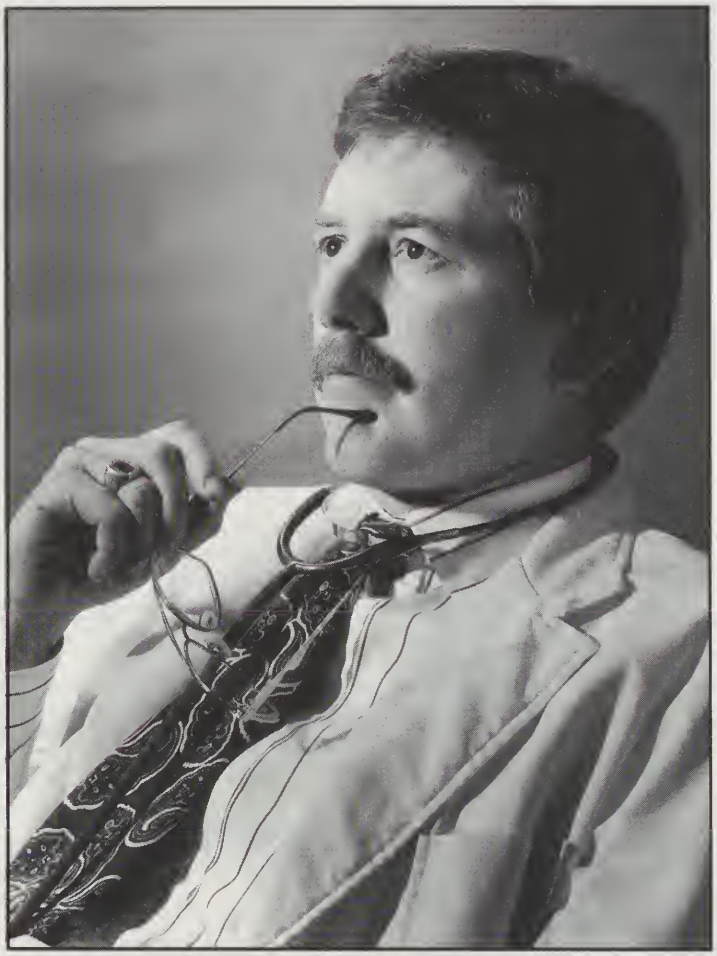

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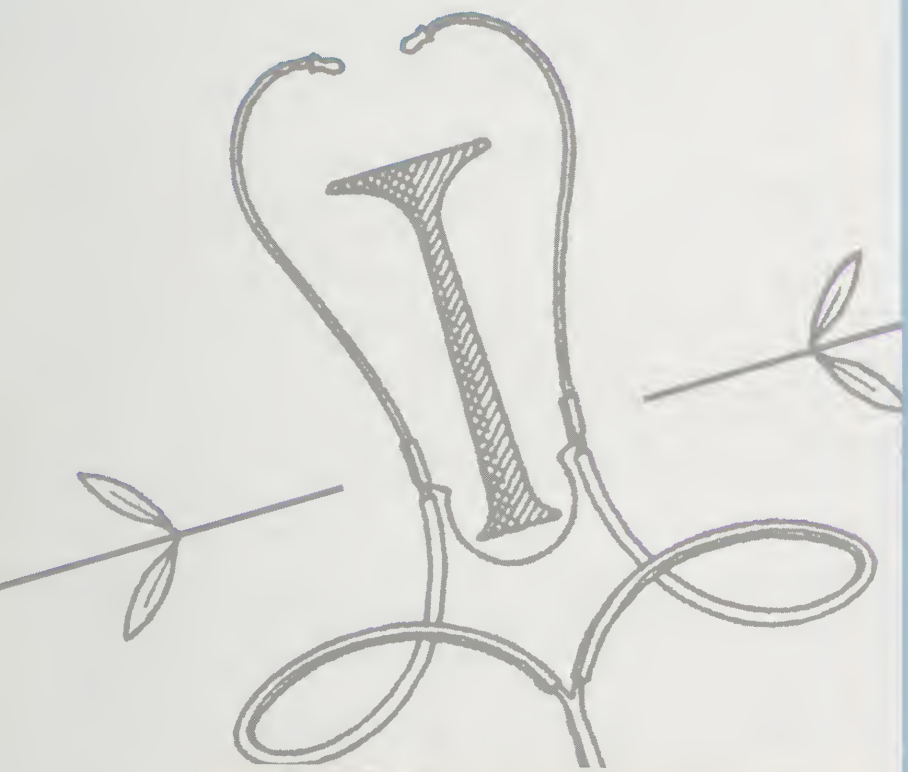
Summer/Fall 1996
Volume 97, Number 2



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KMS

KANSAS MEDICINE

Summer/Fall 1996
Volume 97, Number 2

Kansas Medicine (ISSN 8755-0059) is published quarterly by the Kansas Medical Society, 623 SW 10th Ave., Topeka, KS, 66612. KMS membership includes a one-year subscription for which $15 is allocated from each member's dues. Rates to others: $30/year domestic; $45/year foreign. Printed by Graphic Promotions, Topeka, KS. Periodical postage paid at Topeka, KS and at additional mailing offices. POSTMASTER: Send all address changes to *Kansas Medicine*, 623 SW 10th Ave., Topeka, KS, 66612.

Indexed in *Hospital Literature Index* and *Index Medicus*. Available through University Microfilms. Listed in *CC/Clinical Practice*. Search Resource for Institute for Medical Information, Inc., and Medical Search, Inc.

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Not goals but transitions . . .

Some physicians say the "golden days of medicine" are gone, and managed care is responsible for the destruction. Still others blame market forces for the recent "commodification" of health care. Regardless of why or how, your world is changing, and here at KMS, so are we.

The Kansas Medical Society dedicates itself to providing physicians the tools needed to compete effectively in medicine's changing environment. Through a coordinated communications process, we strive to provide current and accurate information essential to the physicians of Kansas.

In the mass media market of the 1990s, a reader has to choose; it is simply impossible to read everything that appears in the mailbox. With the advent of computers and the Internet, the Information Age dictates that KMS update itself to remain a vital, contemporary source of physician information.

With this issue, *Kansas Medicine* debuts a fresh look. The Journal's new layout is designed to streamline the reading process and enhance visual appeal. We have changed the print to allow for easier scanning of articles. The addition of quotations set apart from the text allows readers to evaluate articles quickly. Because articles do not jump from one page to another and back again, the organizational format facilitates quick location of interest areas.

From changes in format to changes in staff, *Kansas Medicine* has survived this year of transitions. The rebirth, however, was not without its complications, and unforeseen circumstances have delayed your receiving this first issue. For that we are truly sorry.

The Editorial Board has embraced this evolutionary process and as the page turns to the 21st century, *Kansas Medicine* pledges to continue the tradition of excellence it began in 1901. KMS

Not in his goals but in his transitions man is great.

~~Ralph Waldo Emerson
The Journals and Miscellaneous Notebooks of Ralph Waldo Emerson, Volume V

What's new?

Warren E. Meyer, MD

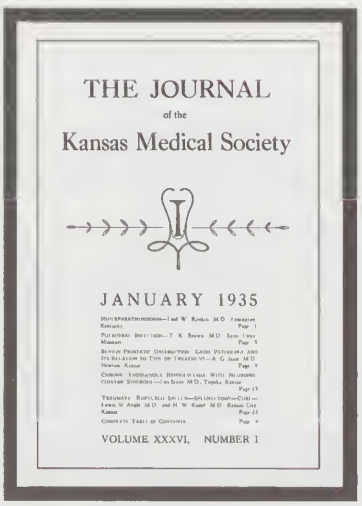
For many years members have heard the report of the Journal at the Annual Meeting of the Kansas Medical Society. You have listened as the Editorial Board expressed its great appreciation for the Society's generous subsidy of the Journal, *Kansas Medicine*.

It may surprise many of you to know that in its early beginnings, the Journal helped financially support the Society through its advertising revenues. Those of you who have served as delegates in recent history are aware of the problems we have had with the decline in advertising revenues. While this persists as a serious problem, we continue to seek new advertisers.

In recent actions, the Editorial Board has tried to confront some of the Journal's biggest challenges, and in 1995, the production of *Kansas Medicine* was altered to a quarterly publication.

This issue brings you more changes which the Board hopes will not only ease the Journal's mounting financial pressures but also provide readers an eye-pleasing and mind-stimulating magazine. Some of the changes appearing in this issue include the following:

- The new paper for *Kansas Medicine* is less expensive and can be purchased annually with paper for KANSAS PHYSICIAN.
- Two color printing (the new cover) is much less expensive than four color printing (the old cover). Again this will reduce the publication costs.
- The logo, which is uniquely *Kansas Medicine's*, was designed expressly for the Journal by the renowned Topeka graphic designer, Bradbury Thompson, a friend of former editors, Drs. W.M. Mills and Lucien Pyle. A combination of Rene Theophile Laennec's first "stethoscope," and its more modern counterpart, along with leaves of foxglove, tie together medicine's past, present, and future. The logo first appeared on the cover of the January, 1935 issue and has been on every cover since that time. Dr. Orville R. Clark, former editor of the Journal, wrote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VOLUME XXXVI, NUMBER 1

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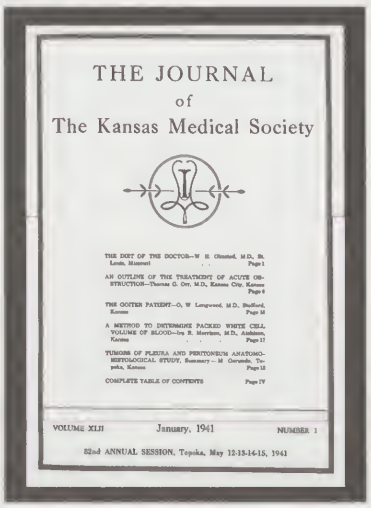
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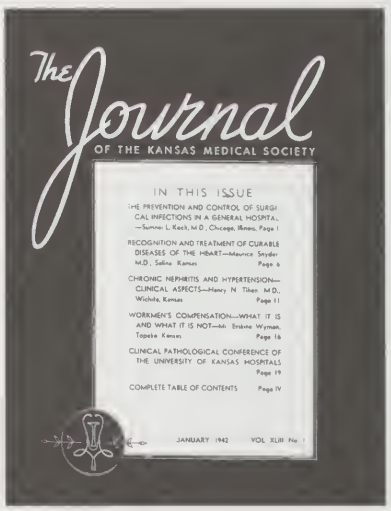

The Journal
OF THE KANSAS MEDICAL SOCIETY

IN THIS ISSUE

1942

in 1955 that the logo, "has become as much a part of the Journal as any of its features on the inside, and is something which is ours alone." The Board felt strongly that this symbol of our heritage should continue to occupy a prominent place in the publication.

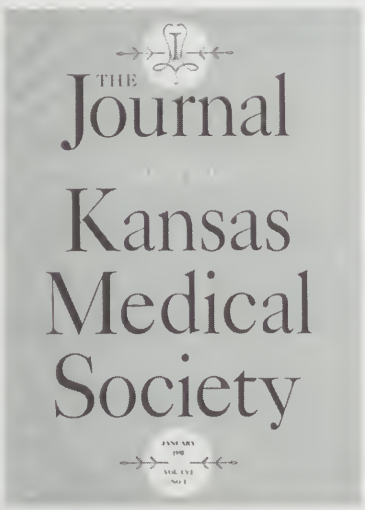
- Some new departments are making their debut. *In Memoriam*, lists obituaries of deceased physicians; *The Last Word* contains comments by members on questions of current interest to medicine; and *Lest We Forget* reprints excerpts of current interest from previous editions of *Kansas Medicine*.

Reprints of various covers of the Journal over the years are reproduced below to show that *Kansas Medicine* has undergone many changes over its long and distinguished career. The Board plans to preserve the tradition of excellence established in 1901. As is always the case, we need the input of our readers to be certain that we respond specifically to your needs, concerns, and wishes. KMS

If you have any questions or comments about the new format, feel free to contact Allison Peterson at the KMS office, 913.235.2383 or 800.332.0156. We look forward to hearing from you.

Publications which continue through numerous years are confronted with an interesting problem. If changes in format and arrangement are not frequently made, the publication soon finds itself operating in a stereotyped, monotonous manner with a format which is obsolete and not in keeping with progress.

***~~Kansas Medicine* Editorial, 1941**



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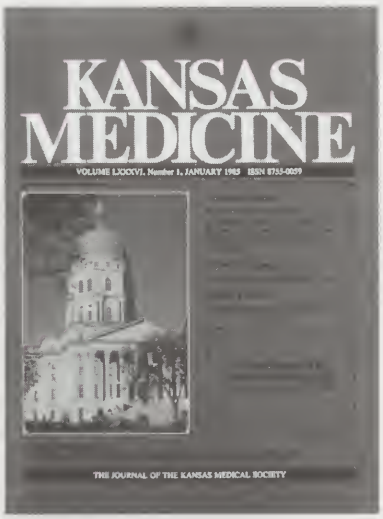

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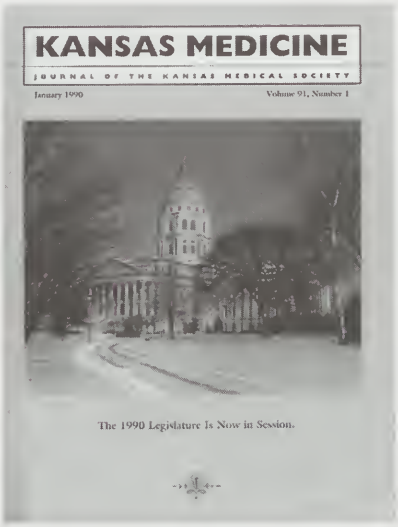

1990

Kansas is like its wheat: tough and firmly rooted

Richard V. Ohmart, MD

I'm driving across Kansas—actually zig-zagging across Kansas. As a native Kansan, reared and educated in the state, it's nothing I haven't done a multitude of times. Yet there are certain scenes and sounds, both familiar and unfamiliar, that thrust themselves at me on each trip. I am alone today, so perhaps I am more sensitive to some of these stimuli.

My trip starts with a visit to the Farm Services office in Scott City, then east on Highway 4 and a stop or two at wheat fields. After wandering out into the fields, I stoop to pull some of the sparse, foreshortened plants. Dry they may be, but firmly anchored in the soil, with a good taproot. In spite of all the dire predictions, moisture at the right time might yet bring a tolerable crop to fruition. Of course, wind with no moisture will prove disastrous.

Following Highway 4 through the small towns that dot its western path demonstrates again the curious juxtaposition of apparently dying towns, composed primarily of uninhabited, tumble-down buildings, but each with an occasional new home or business. Ransom, of course, has become well known for its EACH/PCH arrangement with Hays Medical Center.

To my right I see a remarkably green and vigorous field of wheat; it stands out like a flag in the tan and gray landscape. As I pass it, I see the pipes and ditches that tell me it is an irrigated field. No wonder! I stop to take some pictures of a decrepit house, and the lone tree next to it, wondering what joy and sadness once reverberated through that home. On my way back to my car I startle a pheasant, and once again I am struck by that bird's impressive color scheme.

At Wakeeney I join the interstate, both for ease of driving and to speed my journey. But my reveries about Kansas are not over. I usually drive a "safe" five miles above the speed limit of 65 and pass three cars for every one that passes me. Today, at the same speed, I am passed by ten cars for every one I pass. The ratio increases as I near Topeka and Lawrence, in spite of a roiling wind, which moves me across the two lanes of traffic as it chooses.

It is State Basketball Tournament weekend. I meet the buses from the small schools headed west for Hays and Manhattan, each painted with signs indicating that it, and only it, contains the best basketball team in the state. Each is followed by its own convoy of painted cars, vans, etc. I pass bus caravans from the larger schools headed for Salina and Topeka and the large school tournaments. One McPherson bus appears to have a trailer in tow, perhaps carrying band instruments. I dimly remember my high school days and similar trips. Much brighter are the memories of my children's high school days, and the excitement felt by the entire community when our team actually won the state tournament.

I stop at a Stuckey's for gas and a brief rest. Inside I notice a tee shirt stating

I Love
To See
Kansas
In My Rear-view Mirror.

Clever, perhaps, but I don't agree with it. There is also the usual assortment of Oz shirts, jokes, etc. For good or bad, we are inextricably entwined with Baum's book.

Back on the road I do a little bird-watching. The harriers of Kansas have been replaced by red-tailed and red-shouldered hawks as the most numerous large birds I see. A red-tail, hovering over the highway in the wind, veers slightly, revealing the magnificent tail coloration that gave him his name. Perhaps the earth and plants are not yet showing their spring colors, but the birds certainly are.

Driving past Fields of Fair winery brings a smile. I am just back from a four-day CME program in the Napa Valley. But our Kansas wine has its own bouquet. This also kindles memories of my wife singing, "Oh, They Say to Drink's a Sin in Kansas," a folk song about dry Kansans voting liquor out

Practicing medicine here is frustrating, rewarding, all-consuming, fun. It is never boring.

KANSAS IS LIKE ITS WHEAT: TOUGH AND FIRMLY ROOTED

Continued from page 7

while "drinkin' all they kin." She especially enjoyed singing that ditty for the Reverend Dick Taylor, then head of the Kansas United Dry Forces. Dick, a man with a sense of humor, seemed always to enjoy her gentle ribbing.

Dotted across the state I note the ubiquitous "Abortion Stops a Beating ❤" signs. The KU and K-State logos are displayed in various fashion; one farmstead apparently has ties to both. I spot a barn with "No God, No Peace; Know God, Know Peace" painted on the side. At the end of the barn is a large, round hay bale with a sheet bearing a painted KU Jayhawk. I enjoy the juxtaposition. As I near Topeka, I am struck by several signs I have not seen before. One large billboard advertises "Vasectomy Reversal, Money-Back Guarantee," and lists a Houston phone number. I wonder how many of the men zipping past me, no doubt in a hurry to get home to their wives, would be interested in such a procedure. Another billboard, featuring a scantily clad (or perhaps unclad—with hair strategically arranged) blonde urges me to stop at "The Best Gentlemen's Club in the Midwest." I wonder whether this is a high-class strip joint, a house of prostitution or merely another "Hooters"—but not enough to follow the posted directions to the club itself. I also wonder if they care there whether one's vasectomy has been reversed or not. "Potawatomie Bingo! Big Bucks!" reads another sign. I wonder if the play on words is intentional or accidental.

The radio provides equally diverse entertainment. Music ranges from Rockin' Jesus through the travails of a man "Old Enough to Know Better But Still Too Young to Care" to Debussy's "La Mer." The unctuous tone of the National Public Radio announcers analyzing Bob Dole's chances in the New York primary the next day are counterbalanced by the hoarse exhortations on the Christian stations.

The only non-changing factors across the state are the wind, the need for rain, and the colors of the earth and plants—all told, a fascinating journey through the microcosm that is Kansas.

Reflecting the climate and geography of their state, the people of Kansas, with whom I have lived my entire life, are a hard-headed, similar, but yet diverse group of individuals. It is little wonder that they have a strength and endurance that sustains them through hardship and suffering, an exuberance that in good times bursts out in excess, and an optimism that spring is just around the corner and the wheat will survive. They are as tough as that hard winter wheat, which struggles all across the state this year. These characteristics are nowhere better demonstrated than in rural western Kansas. Practicing medicine here is frustrating, rewarding, all-consuming, and fun. It is never boring. KMS

The author is a family physician. Readers may address correspondence to the author at New Frontiers Health Services, Inc., 123 Center, P.O. Box 756, Oakley, Kansas, 67748.

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Don't let silly errors mar your writing

S. Satya Murti, MD

Our illustrious predecessor, Galen, realized the importance of clarity in spoken and written communication. He remarked almost 2000 years ago, "The chief merit of language is clearness, and we know that nothing detracts so much from this as do unfamiliar terms." The ability to write followed the development of language closely. Durant calls writing the "greatest human invention since the coming of speech." There are many brilliant writers among the ranks of physicians. The pressures of daily routine, however, blunt our linguistic edge. We have an understandable and conscionable need to abbreviate, syncopate and sacrifice style to content. We share this need with other professionals in physical, biological and monetary sciences. We split infinitives, dangle participles, run sentences into each other and fondly embrace neologisms.

At times, however, our errant ways are more flagrant. We write in a distrait and thoughtless manner; the results are sometimes innocuous, and sometimes humorous. If we consistently defy Galen's caution, though, we suffer unpleasant consequences at the hands of reviewers, attorneys and consumers. Creeping errors have spared no one. Even Samuel Johnson reportedly erred in his seminal work, *The Dictionary of the English Language*. G.B. Shaw despaired of the ways of the English, who "have no respect for their language, and will not teach their children to speak it." Thus, we are in august company when we err unwittingly. This excuse notwithstanding, remember that those who read us derive mischievous delight, or malicious slight, from our written errors. Following are a few examples I have come across recently. I hope they will stress my point that with careful writing we avoid embarrassment and self-incrimination.

- This pulmonologist's care was excellent. His notes and discharge summary attested to his kindness and dedication. His good intentions were not in question, until the point where he wrote, "I then left on vacation on the 29th. Following this, the patient made a slow, steady improvement." If you are ever in need of a non sequitur, grab this one.

There are many brilliant writers among the ranks of physicians. The pressures of daily routine, however, blunt our linguistic edge.

- This note is from a podiatrist's history. She finds: "Social history reveals no trauma to the toe. Patient is on Lanolin for his heart . . . [and] on Zantos for his stomach." David Kessler, please note these off-label uses; or did you approve them on fast track?
- Our hematologist is pleading the case of her patient: "To be honest, Mr. C still works full-time, is running on a very low hematocrit simply because he has the desire to." Is this a case of misplaced desire?
- All caution was exercised before "Eurokinase was infused," writes

this reviewer. Caution is, indeed, appropriate. We do not want any Euro-Trash here, especially if purchased with the Euro currency!

- Here is a policy statement on the administration of EPO (erythropoietin): "The following providers may furnish EPO for home self-administration:
  - Medicare approved facilities.
  - Suppliers of durable medical equipment.
  - Suppliers of home dialysis epiphany."

This is a hard one to decipher. Probably the intended word was "company." In any case, we welcome all attempts to introduce divinity into medicine. We shall accept it in any form, whether through prayer or through a home dialysis company.

- A continuing education manual directs our attention to a photomicrograph. This picture depicts: "Sections of the brain showing normal patient." When does one become a normal patient?

- The total hip replacement was uneventful. The day after surgery, our patient lost consciousness. The attending orthopedist, referring to this event, noted in his discharge summary, "On the second post-op day suddenly and without explanation she became unresponsive." How ungracious of her not to forewarn us of her intention to slip into a coma!

- This is another case with an adverse outcome. Nursing notes read as follows: "Dressing changed. Patient was oriented." Whether the patient was, indeed, alert or not is the question. The plaintiff's attorney may well ask: "But doctor, the nurse's note indicates your patient was oriented. Yet, you say that he was unaware of his surroundings, and lethargic? One of you is not telling the truth," he insinuates. Yes, the nurse tried to orient a stuporous patient. Unfortunately, the attorney takes the passive verb (her attempt to orient) in her notes as a descriptive adjective of the state of alertness of the patient.

- Susan Ward, once the managing editor of *Kansas Medicine*, sent me this information from an obituary. "Dr. P died November 2, 1992. Because of this event he is no longer in practice." She can think of no better reason than this to stop practicing.

Sometimes we blunder into obscurity in our zeal to sound learned. For example, Oliver Wendell Holmes chides us for using words like "ligatures" instead of "sutures," for they both stop the bleeding. From France comes another example in Molière's 17th-century play, *The Doctor in Spite of Himself.* In it, a doctor-impostor, Sganarelle, uses meaningless Latin phrases to impress his patients and their families. Sganarelle explains the illness of his speechless (aphasic?) patient as "caused by the acidity of the humors engendered in the concavity of the diaphragm, it happens that these vapors . . . Ossabandus, nequeys, nequer, potarinum, quipsa milus. That's exactly what's making your daughter dumb." None of this makes any sense, but these words certainly impress his patients. Three hundred years later, we still love to write complex sentences stretching out the trite. But where colorful description is called for, we settle for the bleached palette instead.

- Witness the following introductory address of a consultant thanking the referring physician. "Thank you very much for allowing me to moderate this rather obese elderly female . . . . She is related to have a degree of Alzheimer's disease and...is suspicioned to have constipation and diarrhea."

How about this instead? "I thank you for referring __-year-old Ms. __. She weighs __ kgs. She has Alzheimer's disease, constipation and diarrhea."

The above extracts contain few factual errors and no deliberate misrepresentation. They are probably the products of hurry, fatigue or mistyping. Nonetheless, they are funny and, at times, troublesome. KMS

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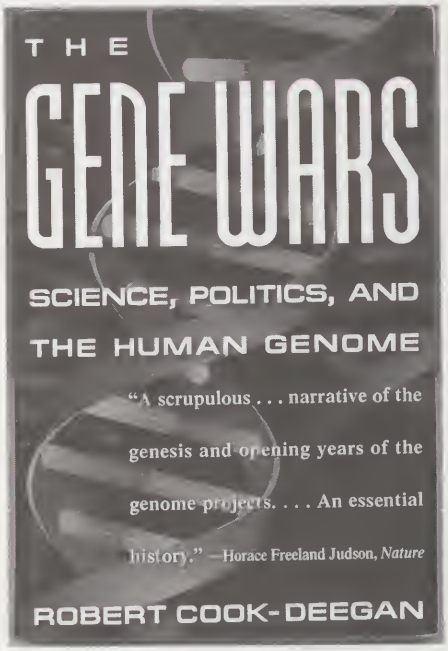
What James Watson and Howard Hughes had in common

Editor Warren Meyer, MD reviewed The Gene Wars: Science, Politics, and the Human Genome, *by Robert Cook-Deegan, M.D. (W.W. Norton & Co, 1994, illustrated).*



The author became involved in the Genome Project in 1976 while conducting a pedigree study on Alzheimer's disease. The subject of the study was the Ross family (not their true name), a family based in Oklahoma, but with ties to Texas, Kansas and Nebraska.

At that time, Dr. Cook-Deegan was affiliated with the University of Colorado. He went on to follow the project as the director of a team from the Office of Technology Assessment from 1986 to 1988, when he left to become executive director of the Biomedical Ethics Advisory Committee, a short-lived committee which dissolved in September 1989. He then worked at the National Center for Human Genome Research, the administrative hub of the Human Genome Project within the National Institutes of Health (NIH), until August 1990. Dr. Cook-Deegan is currently on the staff of the Institute of Medicine, National Academy of Sciences. His background with the Genome Project makes his account of the scientific, political, ethical, and international struggles to make the project work authentic, historical and informative. For the most part, he has been able to remain objective, although his comments indicate his feelings in several portions of this interesting and stimulating book.

The Gene Wars is divided into five parts. The first, "The Scientific Foundation," begins with his pedigree study and proceeds in a chronological sequence to outline the "why" of genetics in general, through the various steps and scientific advances that made the thought of sequencing the human genome into a realistic possibility. Illustrative drawings explain the human chromosomes, different techniques allowing scientists to identify DNA markers on the genes, the cloning of segments for further study, and automated DNA sequencing techniques. This segment offers a "quick study" of genetics.

The second part of the book, entitled "Origins of the Genome Project," begins with the first meeting focused on sequencing the human genome in 1985, initiated by Robert Sinsheimer of the University of California, Santa Cruz. While this did not materialize into the hoped-for project, the Department of Energy (DOE) had been doing research on the genetic changes in DNA experienced by the *hibakusha* ("those affected by the bomb"), the Japanese survivors of the atomic bomb attacks. A series of meetings among famous scientists created much controversy about the project, but little to advance it. There were skirmishes within governmental departments as well for necessary funding and control of the project. Despite some delays, the project was eventually funded.

The third part of the book details "The Support Structure," and introduces an unlikely character, Howard Hughes. He provided financial support when federal agencies did not respond and covered areas not funded by the NIH. In this remarkable way, Hughes left his

stamp on the Human Genome Project as it was taking off from the runway a decade after his death. In this part of the book, the author also describes the Capitol Hill battles as the National Academy of Sciences redefined the project to include mapping of the human genome, while NIH assumed control from the DOE and became the lead agency in the U.S. genome effort. NIH director, James Wyngaarden, appointed Jim Watson, of double helix fame, to serve as the first director of the Genome Project. This, in retrospect, was the ideal choice.

"Genome Gone Global," describes the efforts to make the Human Genome Project a cooperative effort with other nations. Italy, England, Russia and France were early participants. Germany lagged behind because of the complicity of its scientists with the ideological foundations of the Nazi "racial hygiene" programs, and the Green Movement's distrust of science in general. Japan proved to be a special case; while they were five years ahead in processes and techniques for automating gene sequencing because of their interest in genetic changes in the atom bomb survivors, they—and we—were victims of the U.S.-Japan economic trade wars, which prevented use of their equipment. However, despite all the obstacles, a cooperative effort was forthcoming.

The last part of the book deals with "Ethical, Legal, and Social Issues." The Human Genome Project, thanks to Jim Watson's efforts, had five percent of its budget set aside for a committee named ELSI (Ethical, Legal and Social Issues) to study and make recommendations on concerns raised about the Genome Project. One of its tasks is to change the social framework in which genetics is cast. Another subject in this part of the book is the use of DNA in forensic medicine and the courts, and the decision by NIH to patent chromosomal segments. It is unfortunate that personality differences over the attempts by NIH to patent chromosomal fragments complicated the overall project and led to the resignation of James Watson. By this time, however, the project had taken on a life of its own, and the appointment of Dr. Francis Collins to succeed Watson, hailed by all, assured the uninterrupted continuation of the project.

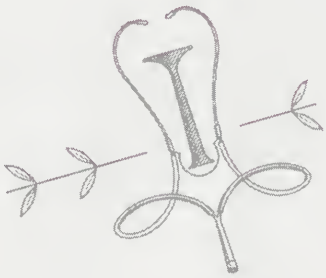
Perhaps the best definition of the book is contained in its last two paragraphs: "The Watson era of the Genome Project ended as it began, subject to the complex interplay of scientific objectives, positions of political power over biomedical research, and contending visions. The purpose of the science was to create precise information about human genes and technologies to explain genetic mysteries. Pursuing that purpose, however, was an inherently political process. It involved individuals vying for power to make decisions—players in the drama by dint of their positions in the federal government and in the scientific community."

"The science of the Genome Project is built on facts; its history, on stories."

The book contains pictures of all the important scientific figures mentioned and a chronology of the political events in the genesis of the project from May 1985 through October 1990, as well as an extensive bibliography and acknowledgments. It is probably, as its cover suggests, "an essential history" of the Genome Project. KMS

A case of contrecoup vestibular injury

Monte F. Hardin, MA, CCC-A



A 39-year-old male gas production worker was attempting to uncouple a section of frozen pipe he thought no longer to be pressurized. During the course of this activity, the pressurized pipe broke and was hurled some 75 meters into a field. In its course, it struck the worker in the left temporal area, causing an approximate 15-centimeter laceration and immediate unconsciousness.

Another gas production worker over a mile away recognized the sound of escaping gas and began to search for its source. Upon his arrival at the accident scene, he found the victim sitting in his pickup truck, apparently after regaining consciousness and crawling to his vehicle. A pool of blood 610 mm in diameter was noted 20 m from the truck. The patient was transported by EMS to a local hospital, where radiological studies revealed a left temporal bone fracture. His only other complaint was that of being "dizzy" and having a sensation of falling to the right.

After two weeks of hospitalization, the worker was dismissed and returned to his home for further recuperation. Throughout his hospital and home stay, he continued to report feeling "dizzy," but denied any nausea with vomiting. Since symptoms persisted, his local physician referred him to a neurologist in our geographical area. Neurological findings were negative with the exception of an intermittent left beating horizontal nystagmus. As the neurologist suspected left vestibular involvement, a referral was made to our facility in Hutchinson for electronystagmography (ENG), auditory brainstem testing and traditional audiometry.

An audiogram revealed a severe high-frequency sensorineural hearing loss in his left ear and a mild high-frequency sensorineural hearing loss in the right ear. Speech reception threshold testing confirmed the validity of the air conduction audiogram. The patient's speech discrimination under quiet listening conditions was normal. Interestingly, the patient did report high-frequency hearing loss prior to the injury, worse in one ear, but he could not remember which. However, he felt his hearing may have decreased in the left ear after the accident.

Auditory brainstem evaluation reflected normal inter and intra-ear latencies with normal morphology, suggesting cochlear hearing loss in both ears without retrocochlear involvement.

Electronystagmography was performed for both positional and caloric-induced responses. In virtually all positions, with the patient's eyes closed, a block or "kip" nystagmus was observed (Figure 1). No true nystagmus with a fast and slow phase was recorded. Surprisingly, caloric-induced nystagmus revealed a right ear unilateral weakness of 22 percent. Warm-and-cool caloric stimulation was perceived by the patient as similar to his "dizziness" but slightly more severe, as the caloric-induced response did initiate nausea without vomiting.

DISCUSSION

Although block or "kip" nystagmus is not in and of itself diagnostic, it has been reported to be seen occasionally in vertebrobasilar insufficiency[1] and arrested communicating hydrocephalus.[2] More importantly to this case, Battin presents a similar type of block nystagmus occurring in patients with post-concussion syndrome.[3]

It is, therefore, concluded that block nystagmus in our patient's ENG should be regarded as, or suggestive of, post-concussion sequela. The force of the blow to the left temporal area created a contrecoup injury to the right vestibular system. It is highly probable that, to some degree, the peripheral hearing in the left ear pre-existed the accident, as this much disparity between hearing ears would be very noticeable with acute onset. Certainly, on this patient's behalf, electronystagmography established his complaint of feeling "dizzy" as a non-psychogenic diagnosis. Ultimately, this related to his time away from the job and may have had significance in a worker's compensation claim. KMS

Mr. Hardin is an audiologist who formerly practiced in Hutchinson. Correspondence may be addressed to the author at 720 Crestwood Dr. E., Evansville, Indiana 47715. *The author wishes to acknowledge the reviewer expertise of Dr. Thomas Smith, otolaryngologist, Hutchinson, Kansas.*

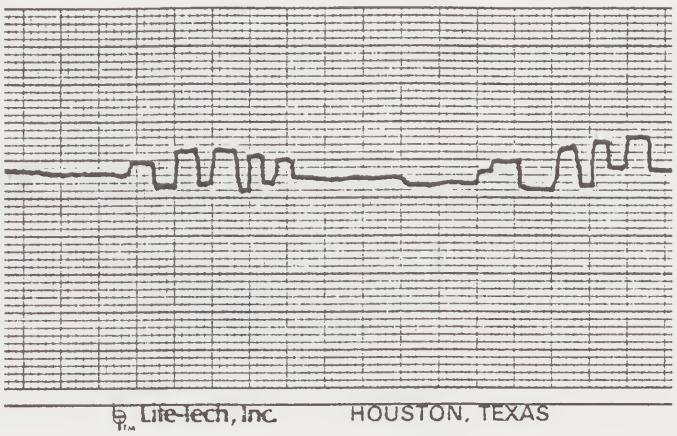


Figure 1. Block or "kip" nystagmus found in all eyes-closed positions.

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Herniated disk: an obscure cause of neurogenic bladder in males

C.H. Hsu, MD, FACS

The obscure vesical dysfunction caused by asymptomatic protruding lumbar disc in the male is rare. In 35 cases reported in the literature, only five have occurred in males.[1] The obscurity and perplexing urological manifestations and the absence of neurological findings usually challenge the urologist in the diagnosis of this condition. Following is a report on the silent neurogenic vesical dysfunction caused by asymptomatic vesical dysfunction in a male patient.

Case Report

F.F., a 28-year-old white male, was admitted to the hospital on October 28, 1991, complaining of terminal dribbling of eight months' duration. He denied any other urological or neurological symptoms. His past history indicated a previous hospitalization elsewhere and urological investigation, including a cystoscopy, performed in June and August 1991. At that time, he was told he had a normal bladder, and that a psychiatric consultation would be of benefit. On admission in October 1991, the physical and neurological examinations were within normal limits. There was no evidence of any apparent neuropathy. On clinical investigation, the urinalysis, urine culture, hemoglobin, blood chemistry and renal function studies were normal. An infusion pyelogram study was likewise negative; however, a cystometrogram revealed impaired sensation and an enlarged bladder capacity with significant residual urine. A Lapides[2,3] supersensitivity cystometrogram with 2.5 mg of subcutaneous injection of urecholine confirmed the impression of a flaccid neurogenic bladder. Cystourethroscopy revealed moderate bladder trabeculation but no apparent vesical outlet obstruction or urethral stricture. A tentative diagnosis of neurogenic vesical dysfunction was entertained. A neurological consultation failed to reveal any apparent neuropathy. A myelogram study showed a protruding lumbar disc at the level of L-3 and L-4. A lumbar laminectomy was performed. The indwelling Foley catheter was removed on the fourth postoperative day. The patient was able to void with a satisfactory stream; however, dribbling continued up to the 14th postoperative day. A follow-up after three months revealed normal cystometrogram findings and no urinary symptoms.

Discussion

Vesical dysfunction caused by a protruding lumbar disc was reported by Love and Emmet in 1967 in three women, all with urinary retention.[1,4] Subsequently 27 cases in females and five cases in males were reported from the Mayo Clinic. The tentative diagnosis was reached by cystometry and confirmed by the myelogram study. It is of interest that in our case a Lapides supersensitivity test with urecholine was extremely helpful in establishing a tentative diagnosis of neurogenic bladder. In the absence of other causes of neurogenic bladder, a silent protruding lumbar disc was considered. A myelogram and neurosurgical consultation are most helpful, and there must be complete cooperation of the urologist and the neurosurgeon.

Summary

A case of neurogenic bladder caused by asymptomatic protruding lumbar disc has been reported in the male. The diagnosis was established by Lapides supersensitivity cystometrogram study.[2,3] After a lumbar laminectomy, the bladder function returned to normal. KMS

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Mennonite roots of psychiatry in Kansas

George Dyck, MD, and Daniel J. Heinrichs, MD

The Mennonite seeds of psychiatry in Kansas germinated in the fertile lowland soils of Friesland, Prussia, and the Ukraine, where Mennonites in centuries past, as pacifists, sought freedom to worship according to conscience and asylum from involuntary military conscription. This asylum repeatedly escaped them as they surrendered the rich loam they had wrested from the lowland swamps in exchange for a new-found promise of freedom from conscription in yet another country. Late in the 19th century, another generation of Mennonites, for the same reason, came to the plains of the midwestern United States, including Kansas.

They were pioneers intent upon doing what they knew best: farming. They brought with them kernels of winter wheat carefully packed in their luggage. They also came with their centuries-old identity built around their low-German dialect, their separateness from their neighbors, and their conviction that if faith in God is to be valid it must find expression in loving deeds for one's neighbor. To nourish their faith, they first built churches. Later they also built schools to educate their young, and hospitals to care for their sick.

For a time, their compatriots who remained behind in the Ukraine continued to prosper and, out of an awareness of need, engaged in institution-building. One of those needs was for an institution in which to care for the mentally ill of their number. They searched for a model and found one to their liking in Germany.

This was a Christian institution serving both mentally ill and retarded at Bielefeld, and operated by a Lutheran pastor named Friedrich von Bodelschwing. A number of Mennonites trained there, in both nursing and psychiatry, returning to the Ukraine in 1910 to establish Bethania (Bethany).[1]

Bethania became a substantial institution eventually housing over 100 patients. Photographs of the buildings and staff document it as a place of stature and dignity. Emil Kraepelin was among its visitors. Kraepelin was a prominent German psychiatrist who described the syndrome "dementia praecox," later known as schizophrenia. The mother of Dr. Elsie Steelberg, a Wichita psychiatrist of Mennonite heritage, served as a nurse there.

Bethania survived the Bolshevik Revolution of 1917 and the period of anarchy and civil war that followed. After the new Soviet Union quit World War I, loosely organized bands of soldiers returning from the German front pillaged the area's prosperous German villages, inviting targets for both ideologues and those just out to plunder. Though many were killed, more died of starvation and disease, with louse-borne typhus the major threat to life. During this time, U.S. Mennonites' awareness of need by their kin was heightened, in response to which they formed the Mennonite Central Committee, a relief agency which saved many from starvation.

By 1922, the authority of the Soviet Union brought some order to the region. The Soviet government took over the operation of Bethania, although its personnel remained largely Mennonite. A report in the German language periodical *Unser Blatt*[2] in 1926 noted that Bethania was filled to capacity, able to admit only the most seriously ill. The year-end census was 107. Of the 204 people hospitalized at Bethania in 1925, 101 were Russian, 87 German and 16 Jewish.

The Mennonite seeds of psychiatry in Kansas germinated in the fertile lowland soils of Friesland, Prussia, and the Ukraine.

The last accounts of the hospital's operation express concern about and then bemoan Bethania's demise in 1927. The Soviet Union's plans for constructing the Dnieprestroy, a giant hydroelectric dam, destined the area occupied by Bethania for flooding. Some patients were transferred to another hospital, but the staff was not. The Mennonites lacked the resources, and the Soviet government the interest to rebuild elsewhere.

Collectivization largely destroyed the Mennonite communities that remained. Those who had not already fled to North and South America were resettled farther east or interned in Siberian labor camps. The German word used by the Mennonites to describe what happened to them is verschlept (dragged in all directions), the same term used to describe a pack of dogs vying for an animal carcass.

Mennonite roots of psychiatry in Kansas

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Mennonites in the New World

The emigrés leaving the Ukraine duplicated in Paraguay and Canada some of the institutions they had left behind. In Kansas, by this time the Mennonites were building general hospitals and homes for the elderly in their communities, but initially there was little interest in facilities for the mentally ill. There is an account of a proposal by Kansas Mennonites to establish an institution for the mentally ill in 1937, but nothing came of it, possibly because few of the Mennonites leaving the Ukraine after the revolution came to the United States.

In the United States, interest in psychiatric treatment was kindled by another entirely different impetus. The Selective Service Act passed in 1940 provided an alternative to military service for conscientious objectors. Initially, Civilian Public Service camps, resembling the Civilian Conservation Corps of the 1930s, became the sites where conscientious objectors essentially replaced Forest Service employees in national forests. Since many conscientious objectors desired to serve over and beyond freedom from military conscription, other options were made available to them in lieu of military service. Acute staffing shortages in state mental hospitals brought about by the war effort made them a good fit for young Mennonite men eager to prove their dedication to service at a time when their loyalty to the nation was suspect.

Between 1942 and 1946, some 3,000 young conscientious objectors, the majority of them Mennonite, spent time serving as orderlies in mental hospitals. These were often crowded, dismal and sometimes frighteningly dangerous places. Philadelphia State Hospital had been built to house 2,500 patients, but had 6,000 with only 200 attendants to provide supervision. In 1950 in Kansas the census at each of the three state mental hospitals ranged from 1,500 to 1,800.

The four years conscientious objectors spent in state hospitals during the war years provided ample documentation for an exposé appearing in the May 1946 issue of *Life*, "Bedlam 1946, Most U.S. Mental Hospitals Are a Shame and a Disgrace."[3] The work of the conscientious objectors was one of several streams of reform following World War II. Best known are the crusade for state hospital reform carried by Dr. Will Menninger to more than half the state legislatures in the country, and the work of Drs. C.F., Karl and Will Menninger in the institutions they founded in Kansas.

The Mennonite Central Committee (MCC), which had provided administrative support for much of the service activity of conscientious objectors, sought ways to continue to provide voluntary service opportunities for young people in the church. There was a broad interest in the church constituency in developing Mennonite psychiatric facilities.[4] Almost every Mennonite community of any size by this time had several members who had experience working with the mentally ill in state hospitals. The model of Bethania in the Ukraine was instructive in helping U.S. Mennonites conceptualize an ambitious national network of psychiatric institutions to serve their own church members.

There were also lingering doubts. Bethania was far removed and did not seem very relevant to them any more. Skepticism lingered about a financing mechanism for such an endeavor, and there was disagreement about whom to turn to for expertise in developing program models. Mennonites were cautious about inviting any outside influence which might serve to undermine their religious faith. There had been bad experiences with the church-founded colleges, which educated young people only to see many leave the church—some, indeed, having become quite antagonistic to the Mennonite faith. Their experiences with some mental health professionals through their experiences in state hospitals did not engender their trust. They certainly did not want anything to do with a Freudian interpretation of their religious faith.

The Mennonites' desire to provide treatment for their own mentally ill finally won out. Their distrust of mental health professionals was not as easily overcome. A smooth working relationship between professional mental health disciplines and the church took years to develop.

A Kansas Treatment Facility

Prairie View, the facility established in Newton, Kansas, in 1954, was one of six centers established by MCC across the country.[5] It started out as a 37-bed psychiatric hospital built with volunteer labor and staffed largely by voluntary service workers. A Mennonite psychologist was hired, but there were no Mennonite psychiatrists available at the time. The board contracted with a group of young Wichita psychiatrists, one of whom was Dr. Tom Morrow, to provide medical direction. He had received part of his training at Friends Hospital in

Philadelphia, the first psychiatric treatment facility established by a church in the United States, and was familiar with the therapeutic community literature that was emerging from Maxwell Jones' work in England.

Prairie View began with its doors locked and relied heavily on electroconvulsive therapy and insulin coma, treatment modalities of the day before the advent of modern psychotropic drugs. Despite early enthusiasm, the community felt increasingly estranged from what looked to them like just another mental hospital. The census declined to a point in 1957 where the board feared closure was imminent. The board believed that the professional staff should become more visible to the public, but with the psychiatrists living in Wichita, this posed a problem. Elmer Ediger, who had been the MCC staff person helping to develop the programs nationwide, became the administrator and hired Dr. Mitchell Jones, who had completed his residency at Menninger, as medical director and sole staff psychiatrist. As a Baptist, Jones passed muster with the Mennonite board. Ediger and Jones together defined the program and carried the message to the local community, and to regional churches, that mental illness could be treated successfully in a caring environment.

This was an era in which the community mental health movement was being defined nationwide. A spirit of optimism regarding the treatability of mental illness was engendered and spread from such places as the nearby Menninger school of psychiatry. By 1964 Prairie View was highlighted in an American Psychiatric Association publication, *The Community Mental Health Center: An Analysis of Existing Models*.[6] Prairie View had succeeded in defining itself as a community mental health center radiating from a core inpatient therapeutic community. Prairie View had grown in its vision from providing a regional asylum for the Mennonite Community to a mission to the community as a whole.

Prairie View became Kansas' first federally designated community mental health center (CMHC) and, as such, qualified for federal staffing and construction grants. Working together with Topeka State Hospital, Prairie View obtained a demonstration grant for providing aftercare. Prairie View demonstrated that early interventions in the community reduced the rate of readmissions, and by using crisis intervention techniques was able to deflect initial admissions destined for the state hospital. The comprehensive community mental health approach succeeded in substantially reducing the number of patients referred to Topeka State Hospital from the Prairie View three-county catchment area while admissions from the rest of the state were still rising.[7]

The American Psychiatric Association recognized Prairie View with its Hospital and Community Psychiatry Gold Award[8] for work in reaching out to the community. The National Institute of Mental Health identified Prairie View as one of its model rural mental health centers and sent many visitors its way. Some concluded that the heavily ethnic community with its stable population was sustaining the community mental health center in a way that could not be duplicated elsewhere. Prairie View restructured its governance in a number of ways to give the wider community a sense of ownership. The board was expanded to include representatives from the community at large, though it remained nominally responsible to the MCC. Each of the three counties represented in the CMHC set up its own advisory board, appointed by county commissioners, to oversee the expenditure of county tax levies. Consultation and educational programs were designed to meet community needs.

When the University of Kansas School of Medicine developed a Wichita campus, Prairie View became a teaching site for medical students and residents in psychiatry. Some graduating students returned to become staff members.

TROUBLED TIMES

Elmer Ediger died in 1983 just weeks after his retirement and some three decades following Prairie View's beginnings. His vision had given cohesion to its mission, and his leadership guided Prairie View's adaptations to the changes taking place in the mental health care environment. Already federal funds for CMHCs were decreasing, and eventually public funding for prevention activities was severely constrained. For some years these activities were subsidized by the hospital, but eventually most were cut back or dropped. In a more competitive environment, the inpatient program could no longer be relied upon to

MENNONITE ROOTS OF PSYCHIATRY IN KANSAS

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generate surplus revenue to support community programs whose costs exceeded income. One of the most deeply felt losses was the clinical pastoral education program which had trained many members of the clergy in the healing influence of the therapeutic community.

Prairie View's operating margin had traditionally been kept low by a board which was opposed to building a depreciation reserve because, in their view, it smacked of profiteering. Hence, little reserve was available for times when the hospital occupancy began to be adversely affected by the reduced inpatient length of stay. The old hospital no longer met the expectations of patients who now had the alternative of newer facilities elsewhere. There was also the expectation of specialized units for specific behavioral problems. A bond issue was marketed to finance a new hospital which was built and opened in 1988.

The staff reluctantly abandoned the therapeutic community encompassing all ages and diagnoses for specialized treatment units. As regulatory bodies and third-party payors became more intrusive, treatment decisions and the structure of treatment programs were increasingly influenced by those who did not have an interest in the unique services Prairie View might have to offer. What they wanted was a standard product rather than the distinctive program Prairie View strived to provide. Some of the changes needed to keep in step seemed to the staff to be regressive, and this required considerable soul-searching as the mission of the organization was reexamined.

As with other Kansas health care institutions, some questioned whether the church should remain involved in what has become a highly competitive industry. Paul Pruyser anticipated this issue when he wrote, "The church-sponsored hospital, if it is to be true to its principles and mission, will . . . have to justify itself by its differences from secular alternatives."[9] The board of directors and the church elected to keep its ties to the church through MCC intact.

PRAIRIE VIEW TODAY

Prairie View has now passed its 40th anniversary. Where it once struggled for acceptance by its founding constituency, it is now a respected part of the community establishment, valued as an employer which keeps the community healthy. The stigma of treatment has diminished to the point where about one of twenty people living in the three-county catchment area receive treatment in any one year.

Prairie View's challenge is to redefine its mission to continue the tradition of a caring therapeutic community in a way that justifies its existence as something more than a local mental health center. As in the rest of medicine, the traditions which transcend the commercial enterprise need special nurturing if they are to survive. KMS

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To tell the truth

Arthur E. Hertzler, MD

A problem which the doctor often must face is whether or not the patient should be told the facts when a cure is extremely unlikely. I was repeatedly informed by ministers in my early days that the sinners at least should be told when faced by a fatal disease so that they could be prepared to meet their God. The average doctor, I believe, is disposed to agree with a statement of Ruskin. "There is but one place where a man may wisely be thoughtless, his deathbed. No thinking should be left to be done there."

The doctor, by the nature of things, focuses on the problem of keeping his patient on this mundane sphere as long as possible and any act calculated to influence this unfavorably is resisted by him. This applies particularly to diseases which frighten the patient, notable heart disease; with proper treatment "heart" patients may have many years of usefulness before them. Therefore, they should not be informed that their condition is serious, certainly not that it is more serious than it really is. The most disastrous results may follow a tactless warning of even the true conditions. The family, or one member of it, may, as a matter of protection to the doctor, be given the true statement of the facts. One must use caution in the selection of the confidant, lest the information be blabbed to the patient, not through viciousness but just through the habit of telling all they know, plus imagination. Patients with goiter hearts particularly are likely to be unfavorably influenced by injudicious remarks as to the seriousness of their condition.

Some patients tell the doctor that they wish to know the truth, and by their bearing convince him that they mean it. I once had a patient of this type, a huge mountain of a man, a noted sheriff of the Southwest for thirty years. His opening remark was, "I am told you tell the truth. I want to know if I have a cancer and if you can do anything for it." I told him he had a cancer and that it was inoperable. After he had dressed, he remarked, "I thank you. What are the charges?" "Nothing," I replied. "Don't do business that way." With this he laid a ten dollar bill on the table and walked majestically down the hall, head up, shoulders back. He had faced bandits and death many times in his career and he did not fear death from cancer. His magnificent personality lives with me still. He was a man.

Sometimes the situations take on different forms. I once had a fine old gentleman with a cancer of the stomach. I told him that all I could do was relieve, in a measure, his pain. He expressed the wish that his suffering would terminate quickly. He said Christ died to save the world; he only asked to die to relieve his old wife and his daughter the care of him throughout the months to which my prognosis condemned him. Though he would leave them moderately comfortable financially, he had not enough to bear the expense of prolonged care. It would mean that they would have to suffer even after his passing. Within a few minutes after I left his bedside he drank carbolic acid, with which, unknown to me, he had provided himself before he called me for my last visit. His was a high type of mind considered from every angle. He was actuated by the highest motives. He was not "temporarily insane" as many tried to indicate in order to excuse his act and he died as he had lived, unafraid, actuated by a desire to extend to his family the final measure of devotion. I am recording a fact. KMS

The doctor, by the nature of things, focuses on the problem of keeping his patient on this mundane sphere as long as possible and any act calculated to influence this unfavorably is resisted by him.

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Geriatric ethics: responsibilities and conspiracies

Nina Ainslie, MD; William Bartholome MD; and Linda Wolter, MD

The Center on Aging at the University of Kansas Medical Center sponsors a monthly discussion of the ethical issues of a geriatric case. The case is presented by a geriatric medicine fellow, and Dr. Bartholome, a pediatrician and ethicist, leads the discussion. The intention is to examine and develop an understanding of the issues involved in the case.

REVIEW OF THE CASE

Mr. E.F. is a 79-year-old man seen for evaluation of slowly progressive cognitive decline and personality change. His family reports memory impairment, unrealistic fears and agitated behavior such as pacing and following his wife around the house. He and his wife live on a farm, where the patient enjoys being outdoors, puttering with farm equipment and occasionally playing golf. He still drives and has never been lost nor had an accident. When his wife leaves him alone at home, he becomes anxious and drives to town to look for her. The wife states that everyone in town knows him and looks out for him. Mr. E.F. is a lifelong gun collector with two unlocked gun cabinets containing many guns.

On exam, Mr. E.F. has no focal neurological deficits. He has difficulty with naming and apraxia. He answers most questions by saying "no" or "I don't know," evading direct questions. He appears embarrassed by his deficits, but states that his family is overly concerned about his memory loss.

Mr. E.F.'s wife and daughter request that he not be told if his diagnosis is Alzheimer's disease. They fear he would become depressed and state he would be "destroyed" if he knew.

DISCUSSION

In Part I of this case, which ran in an earlier issue of *Kansas Medicine*, we discussed the physician's responsibility to protect the patient and the public by preventing Mr. E.F. from driving and using his guns. In Part II, we will discuss the issue of concealing the diagnosis from the patient. Conspiring to hide a diagnosis from a patient used to be commonplace in both pediatric and adult medicine, especially when the diagnosis was a malignancy. Concealment is no longer considered acceptable, though the reasons have been more practically than ethically based.

Conspiring to hide a diagnosis from a patient used to be commonplace in both pediatric and adult medicine, especially when the diagnosis was a malignancy.

In the first place, it is impossible to completely control the flow of information around patients, so a conspiracy cannot be maintained. In pediatrics, psychologists who were interviewing leukemia patients discovered that all of the children knew they had leukemia. Some were worried lest their parents find out the diagnosis, too, and become upset! These children had learned their diagnoses from other children in the hospital.

In adult medicine, maintaining secrecy about a diagnosis is equally impractical. Before treatments other than surgery were available, it may have been possible to conceal a diagnosis—though patients frequently knew they were dying. Now, however, with chemotherapy and radiotherapy available (and what person doesn't know that these are cancer treatments?), patients must know the diagnosis to consent to and undertake the treatment.

Furthermore, we now know that concealment is destructive. When children were not told of their diagnoses, they were unable to talk about their worries, and often imagined implications worse than the actual situation. When they found out the diagnosis, the children lost trust in their parents and physicians. The rupture in their relationships was difficult to repair.

Depriving adults of information about their disease was destructive for similar reasons. Patients could not discuss their feelings and concerns openly, nor make appropriate plans to complete their lives as peacefully as possible. From the ethical point of view, concealing a diagnosis deprives patients of their autonomy, that is, the ability to make informed decisions in their own behalf, whether financial, medical or personal.

The situation with dementia appears at first to be different from a cancer patient. It is less clear that the patient will comprehend and retain the information. As the dementia progresses, the diagnosis will become immaterial to the oblivious patient. However, in the early stages of dementia, many people still have the capacity to make plans and decisions for the future. Making an advance directive and designating a surrogate decision-maker are important tasks that mildly demented patients can still undertake.

To deprive a patient in an early stage of progressive dementia of knowing the diagnosis also deprives the patient of the opportunity to make his or her wishes for future treatment known. For any patients who retain some ability to understand their disease and the implications for their future, it is inappropriate to conceal their diagnosis from them. KMS

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Adenocarcinoma of the anterior urethra in the male

Ossama Tawfik, MD, PhD; Manop Huntrakoon, MD; Mark Noble, MD; Fred Freeman, MD; and Howard Levin, MD

In this paper a rare case of adenocarcinoma in the male urethra is presented. Immunohistochemical studies were useful in differentiating this lesion from the more common prostatic adenocarcinoma.

INTRODUCTION

Carcinoma of the urethra has been known to be the least common among malignancies of the urinary tract in both males and females, especially the former.[1-4] Adenocarcinoma is extremely rare compared to the more common transitional cell or squamous cell carcinomas.[5-7] The diagnosis of a rare urethral adenocarcinoma is usually challenging for the pathologist, particularly in excluding an adenocarcinoma of prostatic origin. We present a unique case of a urethral adenocarcinoma in a 60-year-old male, with a unique histologic pattern. Immunohistochemical studies were used to confirm the diagnosis.

CASE REPORT

A 60-year-old white male complained of a two-year history of dribbling, decreased force and caliber of his stream, and intermittent gross hematuria. He also reported occasional perineal aching, and pain associated with sitting. Urologic evaluation revealed a 4 x 5 cm perineal mass, anterior to the prostate and distinctly separate from it. The prostate itself was only slightly enlarged and without nodularity or tenderness. The mass extended towards the right inferior pubis and seemed fixed in this area. Inguinal lymph nodes were palpably enlarged. There was no peripheral or scrotal edema.

An intravenous pyelogram was normal. Urethroscopy revealed compression of the mid-bulbar urethra by a seemingly extrinsic mass, and the instrument could not be advanced due to near-total obstruction. A urethral biopsy revealed a poorly differentiated adenocarcinoma, thought to originate either from the prostate or the urethra. The patient was subsequently referred to our institute, where a repeat needle biopsy was performed. The patient underwent palliative urinary diversion followed by pelvic irradiation. Pelvic lymph nodes and urethral margins were negative for tumor. He died thirteen months

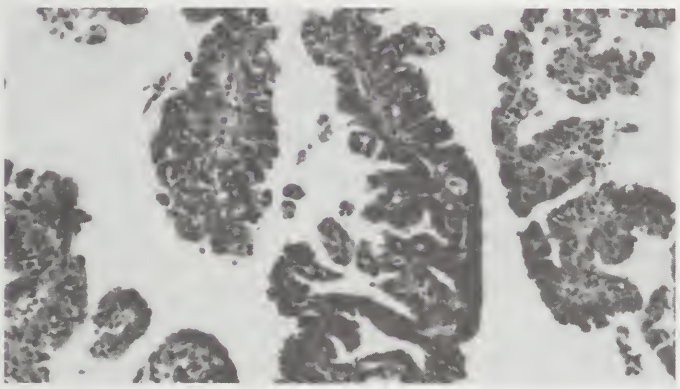

Figure 1. Tumor cells forming papillary structures, reminiscent of the nephrogenic metaplasia (hematoxylin and eosin; original magnification x 40).

later, following progressive malaise due to chronic pain secondary to extensive local metastatic disease.

PATHOLOGIC FINDINGS

The urethral biopsy consisted of four fragments of pale gray-white soft tissue measuring 1.0 x 1.0 x 0.5 cm. In addition to the hematoxylin and eosin and mucin stains, paraffin immunohistochemical studies for prostate-specific antigen (PSA) and prostatic-specific acid phosphatase (PSAP) were also performed. The neoplasm consisted of a complex papillary adenocarcinoma (Figure 1). The fibrovascular stalks were lined by tall, columnar, pleomorphic cells with round to oval hyperchromatic nuclei and prominent nucleoli. The cytoplasm was slightly vacuolated. A proteinaceous material was seen in the lumina of some glands. In some areas, there was a cribriform appearance. Mitotic figures were easily identified in most fields. A repeat needle biopsy showed multiple tumor foci of a less differentiated adenocarcinoma, which had splayed the fibromuscular stroma and occasionally formed glandular structure (Figure 2). Although a papillary configuration was not appreciated, the individual cells looked identical to the ones noted in the first biopsy specimen. The mucin stain was focally positive along the luminal border of the neoplastic cells. The immunohistochemical studies for PSA and PSAP were entirely negative in the tumor cells.

DISCUSSION

Primary carcinomas of the urethra are rare diseases, comprising less than one percent of all urothelial neoplasms.[5-7] Women are usually more affected by the disease, with a male-to-female ratio of 1 to 4. Less than 1,500 cases of primary urethral carcinomas have been reported in the world literature thus far. Adenocarcinoma of the urethra is even rarer. In males it accounts for only six percent of primary urethral cancers, with fewer than 25 cases of adenocarcinomas of the male urethra reported.[1-4] It ranks last in distribution among the major histologic subtypes of this organ, after squamous and transitional cell carcinomas.

Various origins for these tumors in the male urethra have been postulated, including Cowper's gland, Littre's glands, prostatic ducts, periurethral glands and, rarely, nephrogenic metaplasia of transitional epithelium. In the present case, the tumor exhibits a papillary and glandular pattern and appears to be arising from the mucosal surface, making a periurethral glandular origin unlikely. The predominant localization of the tumor in the urethra and negative staining for PSA and PSAP render the possibility of prostatic primary site very unlikely. Furthermore, the prostate gland was palpated clinically as a distinct, separate structure from the urethral lesion. Some areas of the papillary component appeared to be well differentiated and are reminiscent of nephrogenic metaplastic lesions. It is quite intriguing to suspect that this tumor might represent the malignant counterpart of nephrogenic adenoma (metaplasia). Mostofi has alluded to this possibility.[8] Three more recent reports of malignant transformation of nephrogenic adenoma lend further substantiation to this theory.[4,9,10]

Urethral adenocarcinoma frequently presents as a late-stage malignancy. The

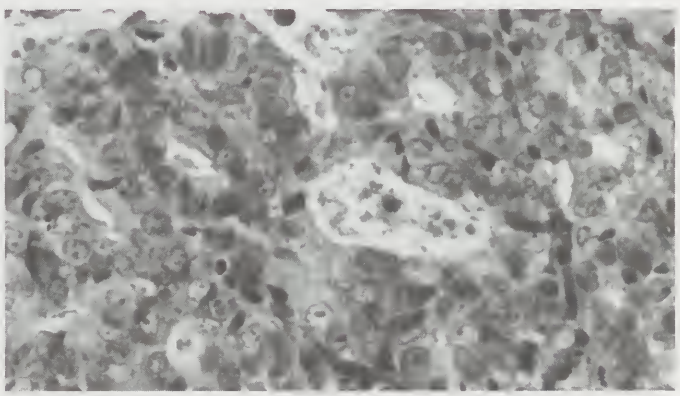

Figure 2. A higher magnification of a solid area of the urethral adenocarcinoma with acinar formation. Nuclei are large with prominent nucleoli. Mitotic figure is noted in the middle (hematoxylin and eosin; original magnification x 400).

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prognosis for these tumors is poor, especially the ones arising from the proximal portion of the urethra. Distant metastasis is unusual, and if it occurs it preferentially involves the regional lymph nodes. Death is most frequently secondary to sepsis complicating local ulceration or to fistula formation. Our patient was no exception, despite radiation therapy attempts.

In summary, we have presented an example of a rare tumor. The urologist and pathologist must maintain a high index of suspicion in evaluating patients with urethral strictures to avoid delay and/or misdiagnosis of these tumors. Furthermore, because of the possible connection of nephrogenic metaplasia and adenocarcinoma in this case, a careful histologic examination is recommended to rule out the presence of carcinoma in those rare benign lesions. A critical evaluation and close follow-up of patients with nephrogenic metaplasia of the urethra is proposed. KMS

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MSSC Auxiliary receives award

Warren E. Meyer, MD

The 31st annual Kansas Wildlife Federation award for 1995 in the category of cleaning up streams was presented to the Environmental Concerns Committee of the Medical Society of Sedgwick County Auxiliary for their efforts to restore the Armour Branch of Gypsum Creek in Wichita that runs west of Towne East from Douglas Avenue south to Kellogg Street.

The pioneer of the program, which began as a simple gesture to pick up trash along the creek, is Mrs. Sylvia (Fount) Hartley. The once-a-month Saturday cleanups soon expanded by persuading the Target store to build a fence to keep trash from blowing into the creek. A local car dealer stopped diverting its waste water into the streams, allowing small trees and plants to grow. The group even obtained a federal grant to make the area a greenway along the creek's banks and to install a bike path. In short, their efforts have turned a "polluted ditch" into a park which is now a healthy home for small fish, mallard ducks, muskrats, cattails, flowers, and a variety of other plant and animal life.

In addition to these efforts at the creek, the Auxiliary has also worked with other community organizations and local businesses to clean up their own waste disposal practices. The citation reads, in part, "They are vigorously promoting good health in the community by providing an environment where people can exercise, breathe fresh air, and thoroughly enjoy the environment around them. It is for these reasons that they are honored as the Kansas Wildlife Federation's Stream Team for the year 1995."

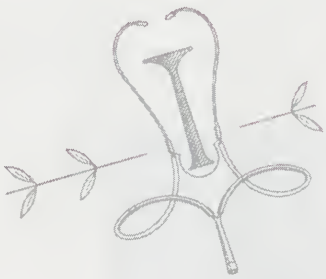
The award depicts a peregrine falcon banking over what is hopefully Gypsum Creek (okay, use your imagination). We would like to congratulate the Medical Society of Sedgwick County Auxiliary for earning this award. A story of their stream clean-up team efforts appeared in the AMA Alliance publication, *Facets*, late last year.

Such activities enahnce the image of our profession, and focus attention on the importance of environmental issues in the community. KMS

Editor's note: Kansas Medicine *would like to thank Dr. La Rue Owen, an avid photographer who has exhibited both nationally and internationally, for making available the slide which accompanies this article.*

Medullary sponge kidney

Lorraine Alvarado, MD, and Anne D. Walling, MD



Medullary sponge kidney (MSK) is an abnormality of the intrapyramidal collecting ducts of the kidney. It is usually identified when pyelography is performed for renal colic, recurrent urinary tract infection, or persistent hematuria. The condition is benign unless complications develop, principally nephrolithiasis and infection.

INTRODUCTION

Medullary sponge kidney is a structural abnormality of the renal intrapyramidal collecting ducts. The lesion is usually discovered when IVP is performed to investigate hematuria, recurrent infection or symptoms of renal stone. MSK was identified in a postmortem specimen in 1908[1] and radiographically described by Lenarduzzi in 1939,[2] but the first complete clinical and morphological description (of "le rein en eponge") was by Cacchi and Ricci in 1949.[2]

As MSK is usually a benign condition requiring IVP for diagnosis, its true prevalence is difficult to assess. Estimates have been made that MSK is present in between 1 in 5,000 and 1 in 20,000 of the adult population, with males and females equally affected.[1,4] In patients attending urology clinics, MSK has been estimated to have a prevalence of 1 in 1,000,[4] but this rises as high as 20 percent when aggressively sought in these selected patients.[2] MSK is identified in approximately 0.5 percent of patients undergoing excretory urography.[3]

ILLUSTRATIVE CASE

A healthy 41-year-old white woman was noted to have experienced up to four "urinary tract infections" per year for over a decade. Not all of these incidents had been well documented, but several urinalysis reports showed mild hematuria in addition to bacteriuria. Two urine samples taken when the patient was asymptomatic and not menstruating also revealed microscopic hematuria. Complete physical examination and initial laboratory testing (BUN, creatinine, PT and PTT) were all normal. An IVP (Figure 1) showed the classical "bristle pattern" of MSK.

PATHOLOGICAL ASPECTS

As the diagnosis is based on radiographic appearance, many cases of MSK are believed to remain unrecognized, and theories of pathogenesis are based on an incomplete and probably biased sample of people with the condition. Currently MSK is believed to have a hereditary basis.[2] Evidence for MSK being a developmental anomaly includes the occasional finding of familial patterns, the frequent coexistence of other anomalies of the renal tract, and the association with other developmental abnormalities, particularly congenital hemihypertrophy, Marfan's syndrome, and Ehlers-Danlos syndrome.[2,4] Histologic appearance and the stability of the lesions over time also point towards a developmental etiology. Alternative explanations of the pathogenesis of MSK are of blockage or damage to collecting tubules by either uric acid crystals or as a result of hypercalciuria.[2]

The kidneys are usually of normal size and shape with pathological changes in uncomplicated MSK confined to the medulla. One or more papillae are affected, and the changes are bilateral in 70 percent of cases.[4] Affected papillae contain dilated ducts and tubules associated with cysts, ranging in diameter up to 7.5 mm.[2] These cysts may contain dry or jelly-like apatite material or small calculi.[2,4] Additional pathological changes may be present due to complications of MSK, particularly infection and nephrolithiasis.

DIAGNOSIS

The diagnosis of MSK is based on the renal appearance during IVP. Minor degrees of MSK may be missed on IVP. The sensitivity of diagnosis is greatly affected by technique. Overlying bowel gas shadows and obstruction of the urinary tract may obscure radiographic changes. Contrast medium in the dilated collecting tubules produces linear radiations which have been likened to the bristles of a brush (Figure 1). If cyst formation is dominant, clusters of spherical lesions will be outlined giving the appearance of "bunches of grapes or bouquets of flowers."[2] Enlarged papillae and evidence of nephrolithiasis, particularly small stones in the pyramids, may also be found. The differential diagnosis includes all causes of nephrolithiasis and/or papillary cavitation such as renal tuberculosis, renal papillary necrosis and pyelotubular stasis.[2]

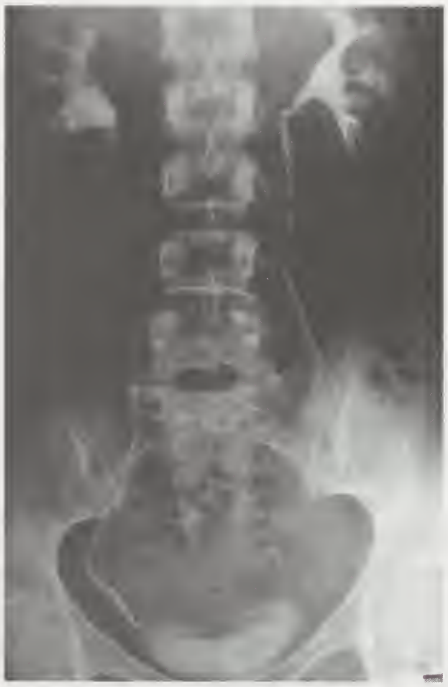


Figure 1. IVP of illustrative case, demonstrating classical "bristle-brush" pattern of medullary sponge kidney, especially in left collecting system.

CLINICAL FEATURES

An unknown proportion of cases of MSK remain completely undiagnosed and/or asymptomatic. Those patients who are recognized usually present between ages 20 and 50 years because of a complication of the condition. One estimate is that approximately half of the recognized cases present as renal colic, and up to one-third as urinary infection. The remaining cases are detected during assessment of hematuria or because IVP was performed to assess hypertension, abdominal complaints or other suspected pathology.[1]

The presentation and management of complicating conditions is similar to that of those conditions in patients without MSK. In young patients presenting with nephrolithiasis, MSK may be suspected if a large number of small stones are detected within the kidneys.[2]

Several biochemical abnormalities have been reported to have a high prevalence in patients with MSK, but it is unclear if these result from complications, particularly nephrolithiasis or infection, or are features of the condition. Patients with MSK are reported to have a high prevalence of impairment of urinary concentration, decreased ability to acidify urine and high fractional excretion of sodium. Proximal tubular function is usually normal, and routine urinalysis is normal unless complications are present. Hypercalciuria is very common in MSK, occurring in between 30 and 50 percent of diagnosed

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cases. The cause of the hypercalciuria is uncertain. Investigations have suggested leakage from abnormal tubules, increased intestinal calcium absorption and hyperparathyroidism. As with other features of MSK, it is difficult to separate cause and effect and avoid conclusions biased by identification of predominantly more severe cases with complications.

Clinical management emphasizes minimizing complications. MSK patients should be counseled that the condition is benign but requires regular monitoring to avoid morbidity from potential complications.[4] The prevention and treatment strategies for these conditions, principally nephrolithiasis and infection, are identical to those advocated in patients without MSK. Patients with a tendency to form stones should be advised to maintain urinary excretion of at least two liters daily and may benefit from thiazide diuretic therapy.[2] Oral phosphate therapy has been suggested as an alternative to thiazides in patients with normal urinary calcium excretion and no infection.[2,4] Some authors advocate periodic urinalysis and culture in asymptomatic patients.

Uncomplicated MSK is believed to have a benign prognosis, and progression of the disease is uncommon. Up to 10 percent of patients are reported to have poor long-term prognosis attributable to complications such as recurrent nephrolithiasis and infection.[4] This estimate is influenced by older studies[2] and may reflect a less aggressive approach to prevention of complications. KMS

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Self-help groups and health care reform

Tim Scanlan, MD, and Greg Meissin, PhD

Over the last decade, self-help groups have increasingly become part of health care. Today there are self-help and support groups for many health problems, addictions and traumatic life conditions, as well as groups for caretakers and parents. Self-help groups are composed of people who share the same problem, life situation or crisis, and might best be described as mutual-help groups. People find in self-help groups individuals much like themselves who are able to share pragmatic insights based on their first-hand experience with the same situation, and as a result tend to find more positive approaches to their problem.

Research conservatively estimates that 6.25 million Americans are currently using self-help groups, and that as many as 15 million have been involved in a group sometime in their life. Most experts believe the figures are closer to 10 million active members, with as many as 25 million Americans having used a self-help group at some time in their lives. In Kansas alone, there are almost 2,000 groups accessible through the Self-Help Network, a statewide clearinghouse operating out of the Department of Psychology at Wichita State University. Research conducted by the Self-Help Network estimates that over 50,000 Kansans are involved in such groups at any given time. At the same time, there are thousands who could benefit from membership in a self-help group but do not know they exist or how to access them. How will the ongoing changes in health care affect the use of self-help groups in the future? It is difficult to understand the role of these groups without discussing the broader topic of health care reform. It is also important to recognize that when we hear of health care reform, we hear primarily about what is going on legislatively in Washington or Topeka, but actually it is occurring rapidly in the marketplace with little influence from our political leaders. Society in general, and business specifically, continues to demand more accountability of the health care provider in terms of outcomes, while improving access to all—and at a lower cost.

To understand health care reform, it is important to consider how health care has been paid for and how that is changing. Episodic care to treat acute illnesses on a fee-for-service basis has been the dominant way health care has been provided. This approach has, in part, increased demand for health care. The system has also become very specialty-oriented, contributing to increased cost. Health care reform is trying to re-orient medicine back to primary care services using specialists only when the primary care physician judges specialized treatment is needed. In 1991, 67 percent of health care was still fee-for-service, but just two years later it was down to 50 percent, and that trend will continue to shift towards both preferred provider organizations and health maintenance organizations, generally referred to as managed care programs. As we enter the 21st century, 80 percent of the population is predicted to be in a managed care provider situation, most with a capitated (prepaid) health care plan. Consequently, the development of large health care organizations that are vertically integrated will provide care as outlined in contracts based on a prearranged cost per person per year for a specified array of services. Since the provider will be required to deliver necessary services to all patients identified in their contract, they will develop strategies that efficiently diagnose and treat those with health care problems. At the same time, insurance companies and corporations are going to look for documented outcomes such as improvement of the health of the insured population, and reductions in cost.

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Groups Can Improve Outcomes and Lower Costs

Self-help groups, as one component in a continuum of care, can increase positive outcomes at no additional cost.

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These groups are cost-free, and finding out how to access them is also free through self-help clearinghouses. Two decades of research on the effectiveness of self-help groups has found that they can positively alter a patient's course of illness, influence patterns of hospital use, reduce mortality rates and prevent relapse. Self-help groups are readily available for a diverse set of health problems, for as long as a person wants, and regardless of ability to pay.

It is anticipated that health professionals will see referrals to self-help groups as a cost-effective adjunct to prescribed health care services once they appreciate how useful they can be to some of their patients. The education of health care professionals about the usefulness and efficacy of these groups presents a challenge to clearinghouses. The Self-Help Network of Kansas will assume a role in this process as it tries to carry the message to the state's health care providers and participates in self-help research.

Unfortunately, self-help groups are often viewed with skepticism, and many professionals do not recognize them as the useful adjunct they are. Others simply view the approach of such groups as "new age psychobabble." In reality, people find support from individuals who have gone through the same experience. While the emotional support found in self-help groups is important, the detailed and accurate information about their disease and the understanding of the local health system found in the collective experience of the members is probably just as important. The more knowledge that health care providers have about self-help groups and the more they interact, the more likely it is that they will find these groups a useful adjunct to treatment.

Changing Health-Related Behavior

Many experts believe that we will see more focus on prevention and health promotion because it is ultimately less expensive to keep people healthy. However, this will be a huge challenge because of the obvious requirement that people take more responsibility for their health and actually change their health-related behavior. Unfortunately, our current system does very little to encourage individual responsibility. It is important to recognize that self-help groups are based on people taking personal responsibility for their own situation, while also helping other members of the group. Studies have found that persons in self-help groups are better at following medically prescribed courses of treatment, show improved lifestyle changes suggested by their physician to prevent relapse, and are less anxious and depressed regarding their illness. People are also more likely to go to a self-help group if referred by their health care provider.

Kansas is a unique place for self-help. There are more self-help groups per capita in this state than in any other, and the Self-Help Network has made nearly 20,000 referrals to self-help groups in the last two years, more than in any other state except one. Kansans are strong, self-reliant people who possess a spirit of volunteerism and a willingness to help their neighbors. This "natural resource" is really what self-help groups are about, and why they are so prevalent in Kansas—helping others who share one's situation while helping oneself; responsibility for oneself and responsibility for others. A critical component of health care reform is how to get the American people to take more responsibility for their own health. In their quiet, grassroots manner, meeting in church basements and hospital conference rooms in virtually every community, self-help groups will play a role and be an asset in this transformation. KMS

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The doctor and his fads

"Lest we forget" is a new department which reprints excerpts from past issues of Kansas Medicine. *This issue's selection was written by J.R. Scott, MD, and first appeared in the June, 1895 issue of the Journal.*

In casting about for a subject, when in an unthinking moment I promised to write a paper for this meeting, thoughts like these filled my mind: "I am too young and inexperienced," for I enjoy the distinction as well as the inconvenience of being the "kid doctor" in a town whose medical men are all young. "I can cram my brain full of other men's ideas, and pass them along, half clothed, to a long-suffering and patient class of men, and they, out of the kindness of their hearts and pity for my weakness would probably not kill me, so my life would be safe; but doctors have enough to stand without me giving them any pseudo-scientific hash."

While these thoughts crowded themselves into my busy hours and occupied my leisure moments, I realized how hard it was for a young man to say anything to interest those of much wider experience. I went to lodge one evening and there was a candidate to initiate, and after the victim had been raised to the sublime degree of "grand high bumper," and order restored, the late candidate looking bewildered and nervous, hardly knowing whether he was really a full fledged member of the Eminent and Royal Order of Shanghais or not, the presiding officer arose and in solemn tones and great dignity spoke as follows: "It is always customary at this point for the new member to make a speech and tell us what he thinks of the order, and how he likes it thus far." And as I sat there I said to myself an epitome! I am the new member and the medical profession of Kansas has asked me to write a paper, and I cannot do better than to tell how the profession appears to me, and how I like it, so I shall occupy a few minutes speaking about the doctor and his fads.

It is generally supposed that medicine is a science. I was taught that, I have heard doctors of wide experience say it was, and yet, to hear those same men talk and see them act makes you doubt it, or at best allow that it is as yet in the embryonic state. After all their knowledge and drill, doctors are turned about by each new wind that blows as are the laity. One is forced to the conclusion that there is more in medicine than scientific knowledge, and that the best practitioners are often not the most scientific.

I have known skilled surgeons to refuse to operate because they could not have made what they considered the necessary arrangements and offer as excuses, "have not the proper instruments;" "the place is not fit;" "it would be criminal to operate, on account of danger of septic infection," and the patient dies without an effort to save him. They were scientific, but not up to what the practicing surgeon or physician should be. They failed when an emergency arrived. Yet I knew of an undergraduate

One is forced to the conclusion that there is more in medicine than scientific knowledge, and that the best practitioners are often not the most scientific.

The doctor and his fads

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living in the knobs of Kentucky, at the hour of midnight, without medical assistance, amid surroundings wholly unfavorable, by the light of a smoky lamp, without tube and with few instruments, successfully perform a tracheotomy and save a child's life. Another in a backwoods district of Mississippi with a pair of tweezers and needles and thread from the work basket of a grandmother stop the blood and close the wound of a would be suicide who had cut his throat with a razor, and the wound healed by first intention too. Another, in like locality, from an old umbrella steel, with a hammer, axe and file manufactured a uterine curette which he needed and did not have time to send for and his patient recovered as readily as if it were shop made. I don't want to be understood as crying down scientific knowledge and investigation; but there are such things as scientific stupidity and plain horse sense in the practice of medicine. I have also observed that the doctor who can spin out the longest Latin names and give in technical language the physiological effects of drugs and the pathology of disease, is not always the one that cures the most cases.

As in other lines, it is the man that gets there, "That hits the spot," that people want, whether he arrives at the proper solution from scientific deductions, horse sense or intuition.

Some doctors know how but can't do; others can do but can't tell why.

In the other sciences, when a new discovery is made it is a fact and remains a fact; but in medicine this year sees many of last year's facts relegated to the rear, only to give way to new facts which in their turn will be given a place beside the blue glass and other extinct crazes. The time was when medical men were too narrow; they could not be moved from the beaten paths of their predecessors. Now let a new idea get into print, particularly if it has the savor of Limburger and bologna, and nearly every doctor is after it like a flock of sheep following the bell-weather over a fence, in fear lest they be called "old fogey" by the so-called progressive medical men.

A number of years ago these ultra-progressive fellows heard something about antiseptics in surgery. You know germicides were all the rage and the progressive men were all off on a chase after some new poison to kill microbes, they traveled so fast to keep at the front that they did not have time to think or they might have discovered what the old fogies did, that absolute cleanliness was the basis and foundation, not bichloride of mercury. Now the progressive men, to use a slang expression, have "come off the perch," but the principle of treating wounds aseptically still lives.

Another fad that followed was the mania for removing ovaries; these same antiseptic surgery men started off and if a woman ever complained of pain in the ovarian region a laparotomy was advised. Every young surgeon considered it the acme of fame to have done one. Surgery received valuable lessons and much knowledge was given to science; but many a woman was unnecessarily unsexed to satisfy the craze.

You all remember what a furor Koch's lymph caused. The newspapers took it up first and reports were all in its favor. The progressive fellows got in the swim again. The microscope became an absolute necessity as a means of diagnosis, all the doubts and uncertainties in medicine were going to give way before bacteriology, in fact a revolution was close at hand; the deep things in pathology were to be revealed. It was proved beyond doubt that the tubercle bacilli caused consumption, and reasoning by analogy all disease was produced in the same way. Now they say, "The microscope has reached the limit of its usefulness, and to chemistry we must look for all future advancement. We are not so sure as we were about the bacilli being the cause of the disease, perhaps it is the effect." Meanwhile the men designated as behind the times, have gone slow and picked up the facts their hasty brethren did not have time to see, and are able to diagnose and treat a case of tuberculosis as successfully as the up-to-date man.

Some doctors know how but can't do; others can do but can't tell why.

Then there is the communion cup fad that has been discussed in the sacred and medical press. No case is cited where disease has been communicated; but the danger, the possibility, is appalling to these progressive fellows and, while speaking, they place between their lips a cigar moistened by lips and rolled by hands far more liable to be polluted by contagion; still they wonder how good church people can take such risks. There may be danger, but there are many other

customs where the danger is greater. Clean out the dirt first, do the dusting afterwards.

Then there are fellows that profess to believe disease is spread by kissing. Poor fellows, it only shows where they go for their caresses. There are lips so enchanting that a microbe would expire in ecstatic delight should he linger on their rosy surface the fractional part of a second.

Kissing is dangerous, Warden Chase and Senator Householder have found that out; but it is not because of any contagion.

Brown-Sequard started the pace in 1889 for a stampede to animal extracts with his elixir of life. And today we have the spectacle of one of America's foremost neurologists at the head of a company that is running opposition to the Erie Medical Company, restoring weak men by injections of that same old elixir under a new name, and to Dr. R.V. Pierce in the treatment of diseases of women by a like process.

The latest fad is diphtheria anti-toxin; judging from newspapers and certain foreign medical journals it is a grand success. Those booming the new treatment tell how the death rate has fallen off, those against how mild the epidemic has been and that, with the other treatment should get the credit. The preponderance of evidence seems to be that the serum craze will soon go the road of tuberculin and that chemistry will drop back alongside the microscope as one, but not the main factor in the diagnosis and treatment of disease.

As a novice I can not see why the American doctor will cry down Paskola, the Keeley cure or Amick's consumption cure or any of the American fakes and take so kindly to those of foreign birth.

In the whole realm of medicine there seems to be an element of credulity and speculation only rivaled by the famous Mississippi Bubble in the early part of the eighteenth century. The condition of medicine today reminds one of the boom times in Kansas, every doctor expects to die famous. The boom will burst one of these days, speculation will stop, credulity will be replaced by common sense, medical men will not become wild over each advance in their science.

Doctors will become what they should be, hard headed men with wide knowledge and a disposition to prove all things and ever ready to advance and perfect their knowledge in medicine. The great discoveries yet to be made will be tested by time and careful, patient investigation and rise like the morning sun growing clearer and stronger as time advances only to set when this material world and the necessity for medical knowledge shall have passed away. Not like a rocket on a Fourth of July celebration rises quickly to the zenith leaving behind a trail of sparks, explodes and disappears in the darkness.

The science and art of medicine has made a very rapid progress in the last twenty years. We have kept such a pace that some of us are dizzy; we have often spoken when silence and more investigation would have prevented our being laughed at by our patrons. The world at large are a shrewd set and when they see grave and dignified professors taking up and advocating a theory, and proving it to be the correct one beyond all question and then repudiate it in a few months or years as being absurd and untenable, there is but one conclusion: "Doctors are either knaves or fools." KMS

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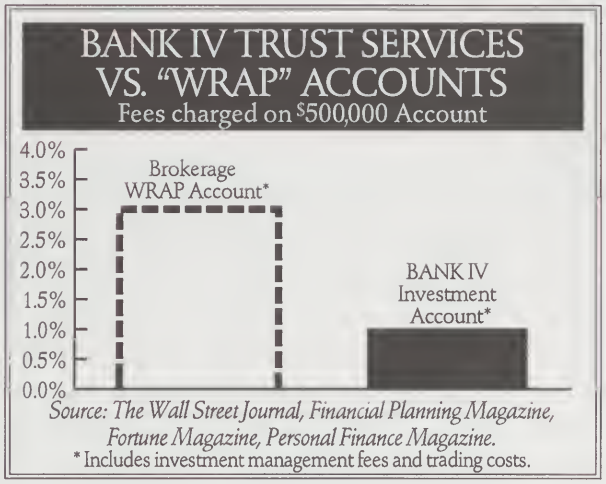

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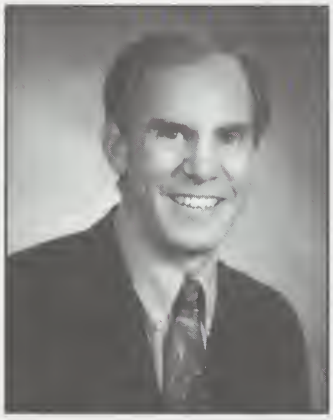
KMS President's inaugural address

David Ross, MD



Dr. Ross's address was presented to the House of Delegates at the 1996 Annual Meeting on May 5.

When Jerry Old and I first went into practice in Arkansas City, we quickly became involved in a lot of practice management problems that we, like most doctors starting out, had not really anticipated. We had to purchase equipment, establish billing and collection procedures, resolve personnel problems, decide whether to participate with Medicare, etc., etc. Within a short period of time, we started to practice a very simple principle (today, it would be called a paradigm). We believed in the simple idea that if we did what seemed right and would appear to be the best deal for our patients, in the long run it would also be best for us. As long as we followed that dictum, we were never sorry.

As the years went by our practice grew, more partners were added, and life became more complicated. We were more sophisticated, but we had more points of view to consider and even more difficult questions to confront. Keeping up with changes in the practice of medicine was our main interest, so trying to stay on top of the changes in the business of medicine was frustrating, indeed. People who were our friends in the past, sometimes became our adversaries. We had to establish new relationships with insurance companies, hospitals, PPOs, HMOs, Medicare, Medicaid, and even with our own patients. We also learned to deal with lawyers, lots of lawyers.

In April, I attended the AMA Leadership Conference in Washington, D.C.. There were hours of very thoughtful presentations and debate on managed care, physician compensation, medical ethics, government policies, and many other interesting topics. These were presented by people who have examined these issues in far greater depth and detail than I would ever hope or want to achieve. After giving some thought to all that sophisticated analysis, however, I heard nothing to change my original belief that putting my patients' interests first would, in the long run, be best for me. The Kansas Medical Society itself was founded on a similar principle. Our bylaws state that, "our object is to unite the medical profession of the state of Kansas in promoting the science and art of medicine and protecting the health of the citizens of the state." We exist to promote our patients' best interests. Now herein lies the trouble! We, as individual physicians, face more and more problems—not just medical problems—but managerial, political, and ethical problems. Some of these dilemmas are so complicated it is often hard to decide which course of action will, in the long run, be the best for our patients.

This environment creates a great opportunity for us as a medical society. We have important issues at hand. What we do in the next few years is going to make a difference.

What are some of the issues that we need to focus on this year? Certainly one of the advantages of following a strong leader like Linda Warren is that there are enough projects and issues already on the table to fill up an entire year. The Interspecialty Council, the KMS-KUMC Liaison Committee, changes in the KMS publications, the development of the western Kansas office, the work of the Task Force on Practice Issues, and the establishment of the KMS Foundation are all very significant programs which must be continued. There are very important legislative efforts in progress that could potentially have

major impact on the problems of insurability that many of our patients face. We need to keep abreast of these developments and, as patient advocates, influence them when possible. The antitrust relief legislation we support could make huge differences in the types of managed care organizations created to keep our costs low and quality high.

From discussions at our annual meeting, I identified several new areas of interest that need to be pursued by KMS. We need to take a hard look at the Board of Healing Arts. The status quo does not appear to be acceptable to most of our members. There is an increasingly burdensome problem of credentialing with which our members need help. We need to deal more effectively with the end of life issues, i.e., the physicians' role in the dying process.

It is critical that physicians, rather than the courts, deal with laws concerning physician-assisted suicide. The 9th Circuit Court of Appeals in California failed to find a distinction between withholding and withdrawing life-sustaining treatment and a physician-assisted suicide. The Second Circuit Court of Appeals in New York similarly found laws criminalizing physician-assisted suicide to be unconstitutional, and the court found no distinction between the physician's ability to withdraw life-sustaining treatment and the ability to administer life-ending measures. By that twisted definition, many of us would have performed physician-assisted suicide. Clearly, that sort of conclusion was not reached by someone with adequate experience in dealing with dying patients. Physicians need to be involved in this issue, or drastic mistakes may be made.

Another issue that we have to deal with falls into the category of what I would call "growing pains." With the formation and growth of KaMMCO, MSC, Heartland Health, and now MedLaw, we have seen occasions for some of our members to very appropriately question whether the actions we're taking could eventually run counter to the basic mission of the KMS. You'll remember that our bylaws start with the words, "to unite the medical profession of the state of Kansas . . ." Many of you may not know that we have already formed the KMS family of companies mission group, consisting of representatives of KMS, Heartland and KaMMCO. Meeting twice a year, the committee plans to discuss and promote cooperation and common purpose among these organizations. It is our intent to make sure that we do not forget that all of these companies have been formed to improve the practice of medicine for the physicians of Kansas and to promote better health care for the citizens in Kansas.

I am very excited about the possibility of a statewide MSO. I think it is very important that the Medical Society be able to provide an option for those physicians who might not want to sell their practices to a managed care organization, but don't want to risk being "losers" in the world of managed care. I do not think it's important that MSC owns a lot of practices, but I think being out there as an option will help everybody in the state much the same way that KaMMCO has improved the malpractice situation in Kansas for everyone, by bringing competition into the market.

Right now, I feel like the Kansas Medical Society is a big ship, cruising along at full speed ahead on an exciting journey. I'm excited about the fact that this year I get to be the captain. I specifically choose the analogy of the ship's captain because the captain spends a lot of time eating with the passengers, and explaining the ship's features. The helmsman, however, is the one actually driving, and the crew are busy doing all the unseen things it takes to keep the ship afloat. I am here to tell you that we have ourselves one fine helmsman and a heck of a crew. Thanks to them and all of you, we are off on an exciting course. We just need to always stay focused on where we started, where we are going, and why we began our journey. KMS

KMSA President's inaugural address

Carolyn Harrison

Mrs. Harrison's address was presented at the President's Installation at the 1996 Annual Meeting on May 4.

I remember as a young girl, admiring the quilt on my grandmother's bed on Sundays when we would go to visit her. I would admire the colorful patches stitched together by hand, and the beautiful decorative quilting threads that made a design in the quilt. I grew to enjoy her patchwork quilts the most, because they could be made of many different patterns of fabrics, and pieced to make beautiful displays of art. The Alliance and the Medical Society are in a way like a patchwork quilt. People are linked together in the medical family. The pieces of the patchwork quilt represent all the different people of our organizations. We are individual in our attitudes, our lifestyles and backgrounds, yet we share so much of what happens in medicine today.

We are connected by a common thread, and that common thread binds together the four areas of the Alliance that I would like to focus on tonight: AMA-ERF, Health, Legislation, and Membership.

The Common thread of interest in our medical schools and our concern about the future of medicine can bring the Alliance and Medical Society together to raise funds for the American Medical Association Education and Research Foundation. The total of last night's auction (over $11,000) and the past year's total (over $45,000) will help to fund international studies, students' emergency needs, and the medical school's excellence fund. We thank all of you for your continued support.

The Alliance will continue to build a relationship with both campuses of the University of Kansas Medical School, and to educate the students about AMA-ERF funds. AMA-ERF funds, "help the medical student of today become the doctor of tomorrow." We hope to increase the funds collected this year, and the Medical Society can help us through Holiday Sharing Card Sales and attending auctions like the one last night. There is no other charitable organization that helps support the future of medical education except AMA-ERF.

Sharon Scott, President of the AMAA, stated in her installation address last summer at the AMAA Annual Session that, "Just as our physician spouses save lives every day through their skill and knowledge, so do we, as members of the Alliance, through our volunteer efforts."

Let me illustrate this by telling you of several Alliance health projects in Kansas that perhaps saved lives. In 1962, Bertha Milbank, President of the Medical Society of Sedgwick County Auxiliary, initiated a program of the sale of car seat belts. (Cars did not come equipped with seat belts at that time.) Bertha, being the good mother she is, and the good Alliance member concerned about the health of Kansans, purchased two seat belt sets for her daughter and new son-in-law for wedding gifts. Their first visit after the wedding, Bertha was pleased and amused to find that her daughter and son-in-law had installed the seat belts, one for the driver's seat and the other, not in the passenger seat by the door, but side by side in their vehicle. Perhaps this project saved a life with the hundreds of seat belts sold.

Many years ago, polio vaccines that saved lives were given with the assistance of Alliance members. Dr. and Mrs. Bill Cauble of Wichita, and Dr. and Mrs. Kenneth Gimple of Topeka, have shipped medications to save lives in other countries. This summer, Dr. and Mrs. Gimple will be going to the Ukraine thanks to contributions from their community,

their church, and the Medical Alliance. Our Alliance publication, the *Communiqué*, will carry a story of their experiences.

The Kansas marriage license application now requires the signatures of the prospective bride and groom after they read a statement about domestic and family violence being a crime. Thanks to Terrie Browning and her efforts, lives may have been saved.

We are bound by a common thread–just as our physician spouses are concerned and challenged by the health of Kansans, so are we as members of the Alliance. At our fall conference, we will focus on environmental concerns and women's health. The Alliance will continue to work on organ and bone marrow donor recruitment. There are many children and adults still waiting for someone to be a hero.

Our 18 county alliances are bound by a common thread of concern about health issues within their individual counties. Some will work on prevention of teen pregnancy, breast cancer awareness, education about alcohol and drug abuse, bicycle safety, support of International Health, immunizations, and support of the Caring Program for Children, a plan to provide health care coverage for children.

The largest piece of the health patchwork is an effort of the Kansas Medical Society Alliance to join in a nationwide AMA Alliance health promotion called SAVE, which is an acronym for Stop America's Violence Everywhere. The common thread of concern about violence can become a vital part of our mutual efforts across the state to spread awareness of this terrible epidemic and to provide support for victims. The Alliance will share information with physicians and their families about how physicians can often be the lifeline to a domestic violence victim.

Dr. Lonnie Bristow, current AMA President, will address the fall KMS Alliance conference in Wichita on the topic, "How physicians can effect domestic and family violence." Dr. Bristow is also scheduled to address a Wichita middle school of at-risk students, and the Rural Physicians Advisory Committee, as well as medical students at KU Medical School-Wichita. All of you are invited to hear Dr. Bristow on the evening of September 26 in Wichita. Information will follow in the KMS and KMS Alliance publications.

Other plans to focus on violence prevention include the distribution of the flyer, "Hands are not for hitting." These are educational tools to be given to preschools, doctor's offices, or women's shelters to emphasize conflict resolution and nonviolent behavior. We will also promote, "I can choose" coloring books to educate children about conflict resolution. Family care physicians and pediatricians may wish to have their spouses obtain these booklets to give to their patients. They are available from any Alliance Board member, and can be ordered from the AMA Alliance.

We can add another patchwork piece—legislation. The Kansas Medical Society Alliance will work jointly with the medical societies to educate our families about legislative issues. This year, "Get out the Vote," will be our common thread of commitment. We will work to have voter registration drives run by our Alliance members at community hospitals, and to contact physicians and their spouses who are not on the rolls of registered voters.

In February, at our, "Day at the Capitol" in Topeka, we will put the Alliance tagline, "Dedicated to the health of Kansas" into action. We will do blood pressure screening, distribute information about breast cancer awareness, and share information about domestic and media violence.

We will continue to build mini-internships through the medical societies and the communities in which we live. This is a program where physicians are "shadowed" by community leaders, legislators, etc., for one day to see how health care is provided, and it is an important way for physicians to share the reasons they went into the practice of medicine. A micro-mini internship will also be done on, "A Day at the Capitol" where Alliance volunteers will follow legislators throughout the morning to learn what it is like to be a Representative or Senator.

A most important piece of the Alliance's future is membership. Since I did not grow up in a medical family, my thread in the medical family began when I met Paul in his last year of medical school. On his first day of rotation on obstetrics, in his haste to be on time to meet his staff physician, he left his antique pocket watch in the dressing room. The watch was given to the new OB head nurse. I locked up the watch for safekeeping, and later when Paul

KMSA President's Inaugural Address

Continued from page 43

asked if anyone had turned in a pocket watch, I asked him to describe it. After describing the watch down to the intricate detail on the watch cover, I returned the watch to the rightful owner. Many weeks later, after watching Paul give attentive professional care to the patients on my unit, I knew there was more than the antique pocket watch that I liked about this physician, and I joined the medical family.

I later joined the Wichita Residents' spouse group to develop some friends in Wichita. I joined a wonderful supportive group, many who I treasure as friends today.

We are working with a changing membership today. Many of our members volunteer with other community agencies, attend college, devote time to their place of worship and their childrens' schools. Some Alliance members fulfill a very important job as mother, or work full-time or part-time outside the home. Some are physicians married to physicians. With a changing membership, we need to meet their needs. We will continue Lisa's efforts to be time-efficient in our board meetings and to offer one day meetings, making them more appealing to our members.

One of the most important tasks of our membership this year was stimulated by the words of Dr. James S. Todd, Executive Vice-President of the AMA, who spoke at the AMA Alliance Leadership Confluence II in Chicago in February. He asked that the Alliance help the AMA to do a most important task: to restore collegiality in the medical profession.

Dr. Todd saw . . . "loss of collegiality as a very dangerous trend." He went on to define loss of collegiality as, "a sense of competition, instead of cooperation; a sense of fighting over turf instead of teamwork; and letting small resentments grow larger and larger over the days." The spouses of physicians have seen these changing trends occur in medicine.

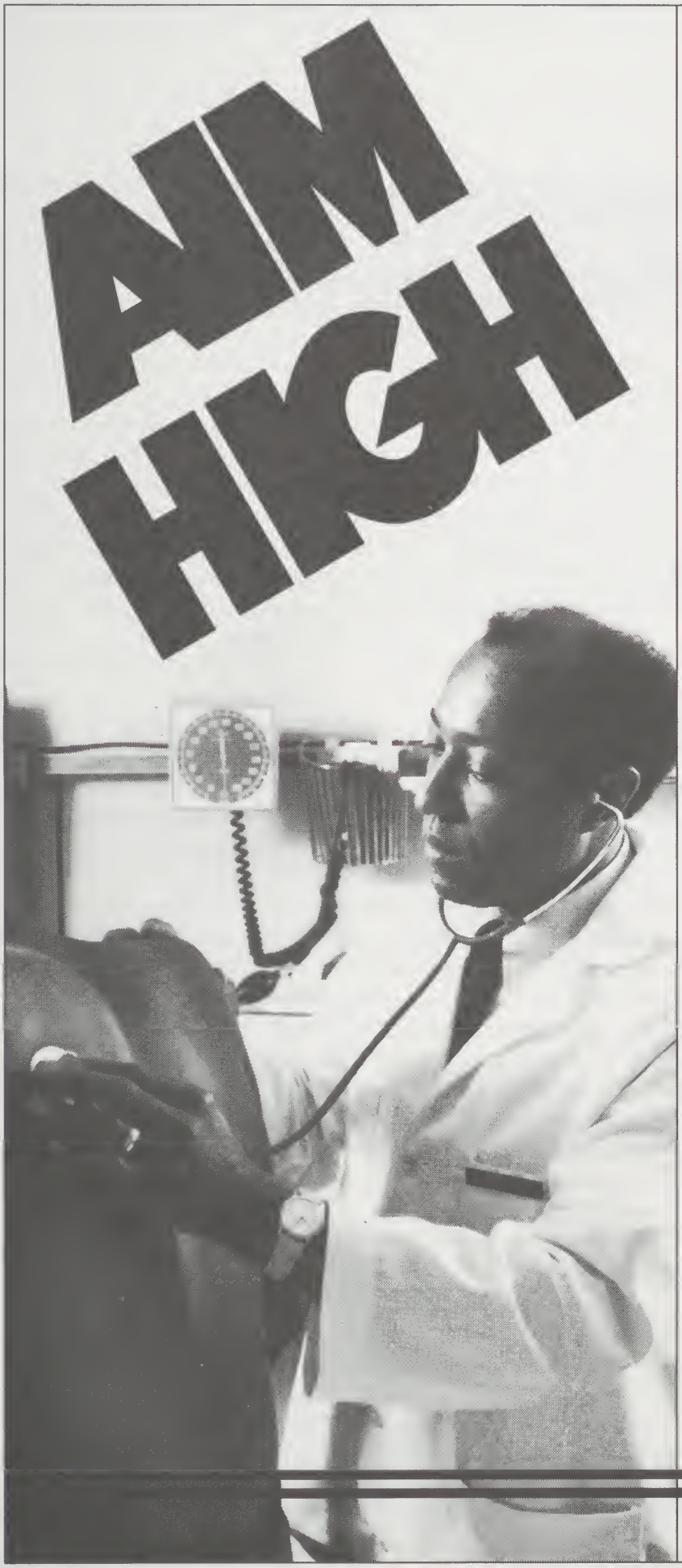
I see, "restoring collegiality" as a goal for the KMS Alliance membership to make those threads of concern and challenges in medicine bind us together, instead of pull us apart. Alliance members need to remind their spouses that all physicians continue to provide the best care possible. We need to remind ourselves that our spouse and other physicians are frustrated not so much with each other, but with the management of patient care.

So how can the Alliance meet this goal to restore "a sense of cooperation instead of a sense of competition, a sense of teamwork instead of a sense of fighting over turf, and not letting small resentments grow larger and larger over the days?" One suggestion is that the Alliance continues to share programs and meetings with members of the medical society so spouses will be informed. We must continue to reach out to new physicians and their families in our communities and have social functions and fundraisers that bring the medical community together to share common interests and goals.

In conclusion, through AMA-ERF, we are bound by the common thread of sharing the responsibility of educating the next generation of physicians. Through SAVE, we can share the responsibility of preventing violence because violence has affected each one of us through either our spouse's practice or through our concern for our childrens' safety in the future. Through our patient advocacy efforts in the legislature, we can share the responsibility of insuring positive health care reform for patients and for physicians. When all these tasks seem daunting, we must remind ourselves of this quotation, "Not one person can do everything, but everyone can do something."

I firmly believe the Alliance has a strong place in today's world–perhaps stronger than it has had before. As we near the 21st century, the county, state, and national Alliances will need to be more tightly stitched together with their medical societies to form a common bond and to insure that the medical profession will be able to meet the future needs of patients.

As we begin a new year, I seek your help, your cooperation, and your support, and I thank you for the privilege of serving as President of the Kansas Medical Society Alliance. Paul and I look forward to working with Dr. Ross and his wife, Rhonda, to "dedicate ourselves to the health of Kansas." KMS



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AIR FORCE

Official proceedings of the 1996 House of Delegates

At 8 am on Saturday, May 4, 1996, the Kansas Medical Society and the Kansas Medical Society Alliance met for a joint opening ceremony for their respective annual meetings at the Ramada Inn, Hutchinson, Kansas. Speaker of the KMS House, Dee Bell, MD, thanked each of the delegates for their presence and participation then announced the order of business for the House.

KMSA President, Lisa Barker, introduced a special guest, the President of the AMA Alliance, Sharon Scott, Roseberg, Oregon. Mrs. Scott brought greetings from the AMA Alliance to the KMS Alliance and the delegates to the KMS House of Delegates. She outlined a variety of projects which show the AMAA's dedication to improving the community. Mrs. Scott shared of the success of the AMA Education and Research Foundation and praised Kansas' contribution of over $30,000 during the past year. She spoke, too, of the increased legislative involvement of the Alliance, and encouraged members to continue their efforts to affect change at the grassroots level. Mrs. Scott also spoke of the Alliance's ongoing SAVE (Stop America's Violence Everywhere) program. The Alliance is working to end violence against children, spouses, and the elderly. "On every level, Alliance members are working to break the silence which surrounds the problems of violence," Mrs. Scott said. On behalf of the more than 60,000 members, Mrs. Scott then asked physicians to encourage their spouses to join the AMA Alliance. "The AMA represents physicians committed to caring for patients, and the AMA Alliance represents physician spouses committed to caring for the community," she stated. In closing, Mrs. Scott thanked Kansas physicians for their involvement in and support of Alliance activities.

Mrs. Barker addressed the assembly, noting that, "timing really is everything." She shared that six years before, she had been installed as the President of the KMS Alliance, and was forced to resign due to the illness of her daughter. This year, however, the timing was good, and the experience of her daughter's illness had made her a better president. Mrs. Barker reported of the Alliance's success to register 200 individuals on the National Marrow Donor Registry. She

announced that representatives of the program would be on hand during the weekend to draw blood, and to add names to the registry. Mrs. Barker noted that the timing was also right for the SAVE program; she thanked Sharon Scott for her vision and participation in that program. Kansas' contributions to AMA-ERF increased 5.3 percent in the past year, bringing the total raised to $43,975.29. The AMA-ERF checks were presented to the medical school deans at the Alliance Fall Board meeting. KMS Alliance membership remained steady during the past year, and Mrs. Barker noted that with KMS' "continued cooperation, we will continue to thrive." On behalf of herself and the entire Alliance, Mrs. Barker thanked and recognized KMS President, Linda Warren, MD, for her dedication to the activities of the Alliance.

Dee Bell, MD, introduced AMA Trustee, Percy Wooton, MD, of Virginia. Dr. Wooten brought greetings from the AMA Board of Trustees. The AMA is the largest medical organization in the world, and Dr. Wooton encouraged all physicians to become members of the AMA. "Physician unity," he stated, "will be the key to medicine's success in the future." Dr. Wooton reported on the progress of the Study of the Federation, an AMA effort to redesign itself in order to better meet the future needs of both physicians and patients. The "vision" of the consortium's report was praised by Dr. Wooton, and he encouraged all physicians to be supportive of the study's main goal, that of increasing the AMA's inclusiveness. Dr. Wooton shared that there had been more medical legislation in this Congress than ever before, and that the AMA had a, "90 percent batting average" in legislative activities. Finally, as a member of the Alliance himself, Dr. Wooton congratulated the KMS Alliance for its efforts. "Out in the community, you are the best PR physicians have," he said. "You truly represent the eyes and ears of the medical profession."

The Speaker invited Dr. Linda Warren to give the President's report. Dr. Warren expressed her pleasure at the opportunity to address the House and share with the delegates the activities of the past year. She also expressed her regrets at the absence of Drs. Jimmie Browning and Craig Concannon, both KMS officers who were unable to attend the annual meeting. "This year is difficult to summarize," Dr. Warren noted, "because it is no longer a plan, but action; the hopes are now reality." The successes though, Dr. Warren noted, could not have been attained without the dedication of the KMS staff, and she thanked them for their hard work.

Each of this year's activities was based on the philosophy that communication is essential. Dr. Warren outlined a variety of accomplishments which occurred over the past year. The Task Force on Practice Issues, created by the House of Delegates in 1995, met to discuss a variety of issues. Dr. Warren thanked Dr. Jimmie Browning for his leadership as the Chairman of the task force. This year also saw the first ever Interspecialty Forum. Every specialty which holds a seat in the KMS House of Delegates was invited to send a representative to the forum. The physicians joined to discuss common issues and concerns as well as some, "specialty specific" issues. Ongoing annual meetings have been planned. Dr. Warren shared her pride in the reactivation of the KU/KMS Liaison Committee which she hopes will build a bridge between KMS and academic physicians. She thanked Don Hagen, MD, the Executive Vice Chancellor of the University of Kansas School of Medicine, for his support of and participation in the committee. KMS has made a commitment to communication through the written word, and to that end debuted KANSAS PHYSICIAN during the past year. The newsletter has brought to physicians a variety of information and viewpoints regarding the many issues facing medicine today. Along with *Kansas Medicine*, both publications will continue to serve KMS members into the future.

KMS membership is at an all time high, Dr. Warren reported. Nearly 87 percent of Kansas' practicing physicians, and over 90 percent of the medical school students are members of the medical society. In the course of the year, Dr. Warren shared that she had traveled to each of the 19 council districts. At various times, she had been accompanied by Lisa Barker who was a terrific ambassador for Kansas medicine. "Meeting with you in your communities," she shared with the delegates, "was truly a reminder that all health care is local."

Dr. Warren observed that Heartland Health, the newest member of the KMS family of companies, was developing a strong reputation around the state. She reported that KaMMCO had again posted another year of success.

Concluding, Dr. Warren noted that she had saved the "best for last"–the creation of the Western Kansas office, co-sponsored by the family of companies. The office opened specifically as an outreach to western Kansas physicians, and was well-received by physicians statewide. "We

OFFICIAL PROCEEDINGS OF THE 1996 HOUSE OF DELEGATES

Continued from page 47

will ask one question when we visit the communities of western Kansas," Dr. Warren stated. "We will ask what we can do for you, and then, we will listen to the answer." She shared her hope in the possibility of more satellite offices in the future.

Dr. Warren noted that KMS leadership was being transferred to David Ross, MD, and she was looking forward to the opportunity of working with him.

Finally, Dr. Warren praised her physician spouse, Roger Warren, MD, for his support throughout the year. She expressed gratitude to the membership for the privilege and honor of serving as their president. "This," she said, "has been the best year of my life. Thank you very much."

Lisa Barker presented Dr. Hagen with AMA-ERF checks for the University of Kansas School of Medicine, Kansas City campus.

The Speaker then declared the Joint Opening Ceremony closed, and announced that the first House of Delegates would convene in 15 minutes.

FIRST SESSION

Speaker of the House Dee Bell, MD, called the first session of the 137th KMS House of Delegates to order at 9:30 am and introduced the Vice Speaker, Robert Barnett, MD. Dr. Bell explained the composition of the House of Delegates, outlined the rules and procedures to be followed, and noted that Davis' Rules of Order would be followed during the meeting. Only delegates would be recognized to vote. All others should convey their opinions to their delegates. Dr. Bell announced that the Reference Committee would meet immediately following the first session. The presence of a quorum was announced, and the minutes of the 1995 House of Delegates, published in the Summer, 1995 issue of *Kansas Medicine* were approved.

Dr. Warren outlined the procedure to be followed for the primary election, if it were necessary to conduct one. She read the slate:

President-elect
Joseph Philipp, MD, *Manhattan*

First Vice-President
Jimmie Browning, MD, *Clay Center*

Second Vice-President
Anne (Katie) Rhoads, MD, *Olathe*

Constitutional Secretary
Robert Durst, MD, *Topeka*
Howard Wilcox, MD, *Hays*

Treasurer
Daniel Suiter, MD, *Pratt*

AMA Delegate
Stephen Miller, MD, *Parsons*

AMA Delegate
Terry Poling, MD, Wichita

AMA Alternate Delegate
Roger Warren, MD, *Hanover*

AMA Alternate Delegate
Craig Concannon, MD, *Beloit*

Speaker of the House
Dee Bell, MD, *Shawnee Mission*

Vice Speaker of the House
Robert Barnett, MD, *Topeka*

There were no nominations from the

Kansas Medical Society Membership

	4-29-96	*1995**	*1994**	*1993**
Active	2533	2524	2347	2248
Active Second Year	78	80	87	77
Active First Year	66	56	40	35
Probationary	74	78	60	57
Resident	266	271	282	279
Student	523	528	344	223
Associate	64	60	49	44
Personal Exempt	31	31	11	8
Retired	523	524	510	507
Military Service	0	0	0	1
Military Exempt	0	0	0	1
Emeritus	52	52	52	55
Honorary	2	2	2	2
Semi-retired	7	7	3	2
Osteopathic Associate	70	62	17	0
Totals	*4298*	*4275*	*3804*	*3539*

* Year end totals

floor. Since there were no more than two candidates for any one office, it was not necessary to hold a primary election. The election would be held during the second session.

Dr. Barnett called for committee reports, announcing that some were submitted as written reports, and placed in the delegates' notebooks.

Treasurer

This report is included in the delegates' notebooks.

Constitutional Secretary

This report may be found in the figure on page 48.

Necrology

Warren Meyer, MD

Dr. Meyer requested a moment of silent remembrance following the reading of the names. This report may be found in the figure on page 50.

Editorial Board

Warren Meyer, MD

Last year at this time we announced that *Kansas Medicine* would be published on a quarterly basis beginning January 1, 1995. Our schedule for publication became quite erratic thereafter for a variety of reasons, and we look forward to more predictable publication dates. We have appreciated the number of you who called KMS with inquiries about your copy of *Kansas Medicine.*

Again, we would like to thank those of you who submitted articles for publication. Despite the experience of other state medical journals that have expired because of lack of articles, we have never lacked excellent articles. We ask that you continue your efforts.

This year we had issues featuring special events such as the Genome Seminar in Wichita, and the 20th anniversary of the University of Kansas School of Medicine-Wichita Campus. Excerpts from the, "Horse and Buggy Doctor," by Dr. Hertzler have revealed a kinship between that pioneer practitioner and his modern-day counterpart. We hope that the articles have been of value to you. Book reviews, especially by Kansas authors, have reappeared and we plan to continue them. The Editorial Board would like to thank President Warren for preparing the President's Message for *Kansas Medicine*, as well as her monthly messages for the KANSAS PHYSICIAN. Knowing how much physicians dislike writing, we are most appreciative of her efforts to recognize the importance of the Journal.

Perhaps the best way to describe our financial condition is that Dr. Kervorkian stands in the wings, looking at us in an increasingly knowing and anticipatory manner. Because of the small circulation and the reduced number of issues, it is increasingly difficult to secure advertising monies from the major pharmaceutical companies. We have also reduced our advertising revenues from professional liability companies to a single advertiser (and I feel no need to reveal its identity.) It is our plan to continue to seek both national and local advertisers. The Editorial Board would like to thank the membership for your moral and most importantly, your financial support.

Again, we would like to thank those of you who submitted articles for publication. We have never lacked excellent articles.

Warren Meyer, MD
Editorial Board Report
1996 Annual Meeting

In February, we received a letter from the Australian Rural Health Research Institute requesting permission to use articles and abstracts from *Kansas Medicine* in a CD-ROM to be distributed to rural practitioners in Australia. We were pleased to comply with the request.

It is important to recognize Susan Ward and Pam Manning who have served on a part-time basis to insure that *Kansas Medicine* remain a fine Journal. We also recognize Nancy Sullivan, who has coordinated all the activities associated with the publication during the transition. Plans call for Susan Ward to continue editing the Journal from Estes Park, Colorado. We look forward to working with Allison Peterson and Linda Austin as the Journal comes in-house.

KaMMCO

Jimmie Gleason, MD

Seven years ago, on June 28, 1989, KaMMCO was formed and it has been growing ever since. Last year KaMMCO took some "hits" for the first time in her history. Approximately 40 percent of Kansas physicians are insured with KaMMCO, but the company recently experienced the loss of about two percent of its insureds due to the non-renewal of two large groups. KaMMCO's unique philosophy—that of

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Continued from page 49

physician advocates who just happen to sell insurance—has brought many other PIAA companies to Kansas for advice. They are impressed with KaMMCO's hard line on policies, as well as the, "family of companies" package of which KaMMCO is a part. KaMMCO has a court record of 46-2. This year saw the beginning of an ongoing program, the Physician Support Program for those physicians who have experienced or are experiencing a suit. Dr. Gleason praised the combined lobbying efforts of KMS and KaMMCO as a true voice in the legislature for Kansas physicians. Dr. Gleason also announced the creation of MedLaw, an in-house legal firm for physicians. The attorneys currently on staff of both KaMMCO and KMS will provide legal services in those areas where the, "medical and legal arenas collide." The Loss Prevention programs for the coming months were announced, and Dr. Gleason thanked the delegates for the opportunity to speak. In closing, he assured the House that KaMMCO would, "never forget where we came from."

Heartland Health

Bruce Gosser

"We have covered lives!" Mr. Gosser announced; currently, Heartland Health has 3500 members. From very "humble beginnings," Heartland is expanding its participation into a variety of programs including Medicaid, the League of Kansas Municipalities, the Kansas Employers Coalition on Health, and Heartland's own Physician Office Product. Of the Physician Office program, Mr. Gosser acknowledged, "growing pains" with the first "roll out" of the program and assured delegates that when the program debuts (again) in the coming months, each of the original problems will have been addressed. Contracting with hospitals across the state continues to progress and there are now 64 members of Heartland's hospital network. The network represents 50 percent of the hospitals in the state and 60-65 percent of the hospital beds. Since January, Mr. Gosser noted, there has been a 65 percent increase in the number of hospitals in the Heartland network. Mr. Gosser recognized the members of the Heartland staff who were present, and thanked the delegates for the opportunity to represent Kansas physicians.

Necrology Report

Name	*City*	*Age*	*Date*
Clyde W. Alexander, MD	Kansas City	90	10-23-86
D. R. Bedford, MD	Topeka	86	8-4-95
Thomas P. Butcher, MD	Emporia	91	4-16-96
Lloyd H. Coale, MD	Shawnee Mission	82	3-22-95
Leslie F. Eaton, MD	Salina	89	7-16-95
Hubert M. Floersch, MD	Lawrence	86	7-1-95
Clell Flowers, MD	Wichita		
John K. Fulton, MD	Wichita	77	8-1-95
Lyle G. Glenn, MD	Protection	83	12-4-95
David C. Hacker, MD	Shawnee Mission	45	9-7-95
Doris Kubin, MD	McPherson	79	5-28-95
David Lasley, MD	Boulder, CO	72	7-15-95
Albert N. Lemoine, Jr., MD	Shawnee Mission	76	11-24-94
Paul Lovett, MD	Wichita		
Ward A. McClanahan, MD	Wichita	73	12-3-95
Franklin R. Miller, MD	Winfield	92	8-22-95
Gerald B. Pees, MD	Lawrence	80	1-30-96
Jesse D. Rising, MD	Kansas City, MO	82	2-15-96
Shelby Rose, MD	Wichita	55	12-18-95
Edward H. Saylor, MD	Topeka	56	8-29-95
Dale Smith, MD	Overland Park	75	10-17-95
Karl W. Stock, MD	Topeka	82	5-13-95
Maj. Martin Swan, MD	Auburn, CA	89	11-3-95
Karl K. Targownik, MD	Topeka	80	1-2-96
Theodore E. Wade, MD	Monte Morelos, MX	92	1-16-96
Theodore Young, MD	Topeka	73	2-1-96

University of Kansas

Don Hagen, MD

Dr. Linda Warren introduced Dr. Hagen and invited him to address the House. Dr. Hagen expressed his honor at the opportunity to speak to the delegates. "This is a challenging time in medicine and education," he said. KU wants to "listen, listen, listen" to the physicians of Kansas. According to Dr. Hagen, "What you need is what we need to hear." He recognized the tremendous opportunities which exist for physicians and KU to work together. "We need your help, and we need to work together," he said. Dr. Hagen shared his strong belief in family practice and a balance of specialty involvement, and encouraged each delegate to honor the, "sacred trust" of medicine by being active with medical students. In closing, Dr. Hagen expressed his personal thanks to Dr. Warren for her dedication to the KU/KMS relationship.

Executive Director

Jerry Slaughter

Mr. Slaughter expressed his thanks to the Alliance for their involvement with KMS, to Dr. Hagen who is a, "breath of fresh air to us at KMS," and to Dr. Wooton for his presence. This weekend, Mr. Slaughter noted, is a time of mixed emotions–excitement at the installation of a new president, but also a bit of sadness as the past president leaves office. "We began our careers in organized medicine together," Mr. Slaughter said of Dr. Warren, the outgoing president and the first female president of KMS. "She is a tremendous ambassador for Kansas medicine." He also shared his excitement at the installation of Dr. Ross, the next KMS president. "Dr. Ross brings a wonderful sense of humor and the perspective of a primary care physician to his position. We all look forward to working with him." Mr. Slaughter recognized the staff of the family of companies and introduced the new additions to the KMS staff since the last annual meeting: Meg Henson, Director of Government Affairs; Mary Sprenkel, Western Kansas Field Representative; Linda Austin, Communications Associate; and Denise Lantz, Finance Secretary. Mr. Slaughter also recognized Nancy Sullivan and Gary Caruthers as key members of the KMS staff.

The greatest challenge physicians face today is that of unity. While diversity is your greatest strength, it also represents your greatest weakness.

Jerry Slaughter
Executive Director's Report
1996 Annual Meeting

This has been a good year for Kansas medicine, Mr. Slaughter said. The family of companies–KMS, KaMMCO, Heartland Health, and MSC–have all worked hard to be advocates for physicians. He offered congratulations to the KMS officers for being on the cutting edge of forward thinking. Politically, Mr. Slaughter noted, this is a crucial year for Kansas medicine. We will be electing one senator and four representatives to Congress, as well as 45 senators and 125 representatives to the Kansas legislature. "You must join KaMPAC," Mr. Slaughter urged. "Our opponents are raising money to support their candidates. Do me a favor and do yourself a favor, join KaMPAC today."

Mr. Slaughter shared with the delegates the necessity of sticking together. "The greatest challenge physicians face today is that of unity. While diversity is your greatest strength," he said, "it also represents your greatest weakness. Beyond the differences in geography, specialty, and demographics, you are all physicians first, dedicated to taking care of patients like no one else can."

On March 5, 1973, Mr. Slaughter came to KMS and this represents the beginning of his 24th year. He expressed his loyalty to the organization and the great, "respect for what you do every day, one patient at a time."

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The Speaker called for unfinished business. There was none.

The Speaker called for new business. Larry Anderson, MD, introduced Resolution 96-28 and it was referred to the Reference Committee.

The rules for the Council District elections were read. Districts needing to conduct elections were 3, 5, 8, 9, 12, and 16.

An invitation was extended to all delegates to attend the Reference Committee meeting immediately following the First House of Delegates. Members of the Reference Committee are: Rick Kellerman, MD, Chairman; Frank Depenbusch, MD, Terry Klein, MD, John Pokorny, MD, and Mary Redmon, DO.

Following several announcements, the meeting was adjourned at 10:29 am.

Second Session

The Second Session of the KMS House of Delegates was called to order by Speaker Dee Bell, MD, at 8:44 am on Sunday, May 5, 1996. Rules by which the meeting would be conducted were reviewed, and the presence of a quorum was announced. Election ballots were distributed, and the Speaker named the Tellers: Warren Meyer, MD, Wichita, and Arthur Snow, MD, Shawnee Mission. While the ballots were being distributed, the Speaker again encouraged the delegates to join KaMPAC.

The Speaker asked Reference Committee Chairman, Rick Kellerman, MD, Salina, to present the committee's report. Dr. Kellerman read the committee's recommendations for each resolution, and Dr. Bell invited discussion and voting by the delegates. (Results of these actions are printed on page 53.) Dr. Bell thanked the Reference Committee for its work.

The election results were announced:

President-elect
Joseph Philipp, MD, *Manhattan*

First Vice-President
Jimmie Browning, MD, *Clay Center*

Second Vice-President
Anne (Katie) Rhoads, MD, *Olathe*

Constitutional Secretary
Howard Wilcox, MD, *Hays*

Treasurer
Daniel Suiter, MD, *Pratt*

AMA Delegate
Stephen Miller, MD, *Parsons*

AMA Delegate
Terry Poling, MD, Wichita

AMA Alternate Delegate
Roger Warren, MD, *Hanover*

AMA Alternate Delegate
Craig Concannon, MD, *Beloit*

Speaker of the House
Dee Bell, MD, *Shawnee Mission*

Vice Speaker of the House
Robert Barnett, MD, *Topeka*

The Speaker called for unfinished business. There was none.

The Speaker called for new business. Larry Anderson, MD, Wellington, presented to the House a motion regarding the case of Stanley Naramore, DO. The text of the motion, which was approved, follows:

The 137th meeting of the KMS House of Delegates affirms the action of the Executive Committee to prepare an amicus curiae brief in the matter involving Stanley Naramore, DO; and directs the KMS leadership to immediately contact the Kansas State Board of Healing Arts to discuss the full implications of the action against Dr. Naramore.

Dr. Bell introduced the Society's new President, David Ross, MD, who thanked the delegates for the opportunity to serve as their president. He spoke of the changes he has seen in medicine and of his areas of interest for the coming year. (The full text of his speech may be found on page 40.)

Dr. Ross announced the newly elected Councilors:

District 3
Larry Riffel, MD, *Overland Park*

District 5
James Gardner, MD, *Manhattan*

District 8
Rick Schoeling, MD, *Arkansas City*

District 9
Pending

District 12

Pending

District 16

Michael Machen, MD, *Quinter*

Dr. Ross installed the re-elected Speaker, Dee Bell, MD, and the re-elected Vice Speaker Robert Barnett, MD.

Dr. Ross then announced that the next meeting of the House of Delegates will be held May 1-4, 1997, at the Marriott Hotel, in Wichita, Kansas. Following several other announcements, the meeting was adjourned. KMS

Resolutions from the 1996 House of Delegates

Resolution 96-1

Physician Responsibility and Cost Containment

Whereas, Cost containment issues dominate the considerations of equity and excellence in national health policy; and

Whereas, An individual hospital's survival depends on its capability to respond to prospective payment incentives by transmitting these incentives to the medical staff; therefore be it

Resolved, That as new reimbursement and health care financing plans evolve, physicians should be reminded that their first responsibility is that of patient advocate and while conscious of costs, the delivery of quality medical care is the physician's foremost consideration.

Resolution 96-2

Smoking & Tobacco Product Sales

Whereas, Numerous studies have found that tobacco smoke is a major contributor to indoor air pollution; and

Whereas, Reliable studies have shown that breathing secondhand smoke is a significant health hazard for certain population groups, including elderly people, individuals with cardiovascular disease, and individuals with impaired respiratory function, including asthmatics and those with obstructive airway disease; and

Whereas, Health hazards induced by breathing secondhand smoke include lung cancer, respiratory infection, decreased exercise tolerance, decreased respiratory function, bronchoconstriction, and bronchospasm; and

Whereas, Nonsmokers who suffer allergies, respiratory diseases and other ill effects of breathing secondhand smoke may experience a loss of job productivity or

may be forced to take periodic sick leave because of such adverse reactions; and

Whereas, Smoking is a documented cause of fires, and cigarette and cigar burns and ash stains on merchandise and fixtures cause economic losses to businesses; therefore be it

Resolved, That the Kansas Medical Society supports a prohibition on smoking in public places and in places of employment, including hospitals; and be it further

Resolved, That the KMS support strict enforcement of laws prohibiting the sale of tobacco products to minors; and be it further

Resolved, That the KMS encourage physicians to take a leadership role in educating their patients and their communities about the hazards of secondhand smoke.

RESOLUTION 96-3

Physician-Patient Privilege

Whereas, Communication between physician and patient, including test results, clinical findings or any other patient information gathered in person or through any medium, are considered confidential and subject to the physician-patient privilege statute (K.S.A. 60-427); and

Whereas, In most circumstances a patient or his or her authorized representative or guardian must consent in writing prior to the release of privileged information; therefore be it

Resolved, That the Kansas Medical Society periodically inform its members of their legal responsibilities relating to the confidentiality and release of privileged patient information.

RESOLUTION 96-4

KMS-KFMC Relationship

Whereas, Endorsement by the Kansas Medical Society is essential for the continued contractual arrangement between KFMC and HCFA to serve as the Peer Review Organization for Kansas; and

Whereas, The Kansas Medical Society in Resolution 90-8 reaffirmed and mandated yearly review of its endorsement (as it has yearly for a number of years); and

Whereas, The Kansas Medical Society through its various committees and subcommittees has interacted with KFMC in a positive and constructive manner; and

Whereas, KFMC has publicly stated that precertification review is the practice of medicine; therefore be it

Resolved, That the Kansas Medical Society reaffirm its endorsement of the concept of peer review and the policy statement of the Kansas Medical Society and the AMA that "peer review is the practice of medicine"; and be it further

Resolved, That KMS endorses KFMC as the PRO for Kansas; and be it further

Resolved, That KMS endorse or not endorse KFMC annually.

RESOLUTION 96-5

Health Care Stabilization Fund

Whereas, The Health Care Stabilization Fund was created by the 1976 Legislature to address a lack of available liability insurance for Kansas physicians; and

Whereas, The Legislature imposed mandatory liability insurance as a condition of physician licensure in order to assure capitalization of the Fund; and

Whereas, The Fund has served its purpose well; therefore be it

Resolved, That the KMS Executive Committee is directed to continue to monitor the status of the Health Care Stabilization Fund closely, including studies and recommendations of the Oversight Committee; and be it further

Resolved, That the Executive Committee shall report annually to the House of Delegates on the status of the Health Care Stabilization Fund.

RESOLUTION 96-6

Amendment to KMS Bylaws-Council and Executive Committee Composition

Resolved, That section 8.11 of the bylaws be amended by deleting the word "and" between "District" and "the" and by adding the following after "KaMMCO"—"the Chairman of the Board of Heartland Physicians Health Network and the Executive Vice Chancellor of the University of Kansas School of Medicine or designee;" and be it further

Resolved, That section 8.12 be amended by deleting "the University of Kansas School of Medicine, the Kansas State Board of Health" and by inserting "the Director of Health, Kansas Department of Health and Environment;" and be it further

Resolved, That Section 8.15 be amended by adding the following after "KaMMCO"—"and the Chairman of the Board of Heartland Physicians Health Network."

8.0 The Council

8.1 Composition

8.11 Members of the Council are the President, President

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Elect, Immediate Past President, First Vice President, the Second Vice President, Secretary, Treasurer, and Speaker and Vice Speaker of the House, Delegates and Alternate Delegates to the American Medical Association, a Councilor from each Council District, the Chairman of the Board of KaMMCO, the Chairman of the Board of Heartland Physicians Health Network and the Executive Vice Chancellor of the University of Kansas School of Medicine or designee. Each councilor and an alternate are to be elected by members of the component societies of the district prior to the convening of the House of Delegates; excepted, that the councilor or his alternate may be elected by a caucus of the delegates if the members have not done so by the date the House of Delegates convenes. The elected alternate replaces an active member in his absence.

8.12 Associate membership of the Council includes alternate councilors and one (1) representative each from the Director of Health, Kansas Department of Health and Environment, the Kansas State Board of Healing Arts, one (1) representative each from recognized specialty organizations and the President of the KMS Alliance. Associate members may attend plenary sessions of the Council but shall not be entitled to vote.

8.15 The Executive Committee of the Council shall be composed of the President, the President Elect, the Immediate Past President, the First Vice President, the Second Vice President, the Secretary, the Treasurer, the Delegates and Alternate Delegates to the AMA, the Speaker and Vice Speaker of the House of Delegates, and the Chairman of the Board of KaMMCO and the Chairman of the Board of Heartland Physicians Health Network. The Chairman of KMS Services, Inc., the President of the KMS Alliance, the President of the Kansas Foundation for Medical Care and the Chairman of the KMS Hospital Medical Staff Section shall be ex officio, non-voting members. The committee shall meet regularly and at least six (6) times during each year at the call of the President, and shall have authority to act in the interim between meetings of the Council upon all matters which would ordinarily require approval by the Council, which do not properly necessitate a special meeting of the Council and which have not been delegated elsewhere by the Bylaws.

8.16 Only physicians who are members of the Kansas Medical Society may serve as voting members of the Council and Executive Committee. All other members of the Council and Executive Committee shall serve in a non-voting capacity.

Resolution 96-7

Formation of the Cimarron Medical Society

Whereas, The Seward County Medical Society expressed an interest in becoming a multi-county component medical society by incorporating Morton and Stevens counties within its organization; and

Whereas, The physicians of Morton and Stevens counties have expressed an interest in affiliating with the physicians of Seward County; and

Whereas, The Seward County Medical Society voted to change its name to The Cimarron Medical Society; and

Whereas, The Council approved this action; therefore be it

Resolved, That the Seward County Medical Society be renamed the Cimarron Medical Society; and be it further

Resolved, That the bylaws be amended as follows:

8.417—Delete the counties of Morton and Stevens.
8.415—Add the counties of Morton and Stevens.

Resolution 96-8

Kansas Medical Directors Association

Whereas, The Kansas Medical Directors Association (KMDA) was formally organized in January 1995 to provide a forum for physicians committed to quality in long term care; and

Whereas, The KMDA membership consists of over 30 physicians, bylaws have been adopted, and officers elected; and

Whereas, The KMDA desires a more formal relationship with the Kansas Medical Society to promote more awareness and understanding of long term care issues; and

Whereas, The American Medical Directors Association is presently a recognized section of the American Medical Association; therefore be it

Resolved, That the KMDA be recognized as an official section of the KMS House of Delegates; and be it further

Resolved, That the KMS bylaws be amended by changing Section 4.5817 from "deleted" to "Kansas Medical Directors Association."

RESOLUTION 96-10

Health Plan Gag Clauses

Whereas, Gag clauses and policies aimed at chilling physician-patient communication are being used increasingly by HMOs and health plans nationwide; and

Whereas, Gag clauses frequently have been construed to prevent physicians from discussing treatment options the plan does not cover, from referring patients for second opinions, and from referring patients to specialists, programs, or centers of excellence outside the plan; therefore be it

Resolved, That the Kansas Medical Society support the American Medical Association in its campaign to educate the public about gag clauses and in its efforts to call on health plans to eliminate the gag clause from their contracts; and be it further

Resolved, That the Kansas Medical Society work with the Kansas Insurance Commissioner and the legislature, if necessary, to address the problem on the state level.

RESOLUTION 96-11

Affiliate and Associate Membership

Whereas, KaMMCO and Heartland Health require membership in the Kansas Medical Society of those physicians who are insured by or contract with those organizations; and

Whereas, Both organizations strongly support maintaining the membership requirement as a means of preserving the important linkage between the KMS family of companies; and

Whereas, Current KMS Bylaws require that physicians from other states seeking associate member status to participate in KaMMCO or Heartland Health must join through a component or county society and pay one-half dues; and

Whereas, It is essential that both KaMMCO and Heartland Health be able to do business with physicians in other states on a competitive basis; and

Whereas, An affiliate member category was created for institutions, facilities, corporations and other organizations that do not qualify for other categories of membership to facilitate the offering of professional liability insurance by KaMMCO; therefore be it

Resolved, That sections 1.62, 1.623 and 1.64 of the KMS Bylaws be amended as follows:

1.62 Members with full privileges except for the right to vote and hold office. They apply for membership through a component society but are assessed less than the full amount of dues.

1.623 Associate Members: Physicians whose principal practice is in another state and wish to affiliate with the Kansas Medical Society. They shall pay dues and assessments as set by the Council; and be it further

Resolved, That section 1.64 of the KMS bylaws be amended by inserting "Individuals" before "Institutions" so that the new section will read as follows:

1.64 Affiliate Members — Individuals, institutions, facilities, corporations or other organizations that do not qualify for other categories of membership. Affiliate members may not vote nor hold office. They may apply directly for membership, and are not required to join through a component society. Dues and assessments for Affiliate Members shall be set by the Council; and be it further

Resolved, That the KMS Council present to the House of Delegates annually a listing of all Affiliate members accepted during the previous year under Section 1.64.

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RESOLUTION 96-12

Guidelines for Supervision and Delegation to Non-Physician Personnel

Whereas, The health care system is experiencing a proliferation of mid-level practitioners and others who work in supervised, directed, referral or collaborative relationships with physicians; and

Whereas, The roles and responsibilities of these personnel vary widely, depending on their training, experience, and the quality of the direction, supervision and delegation by physicians with whom they work; and

Whereas, To assure quality, physicians have a responsibility to be actively involved in and knowledgeable about the care provided by personnel who work under their supervision, direction or referral; therefore be it

Resolved, That physicians have an ethical duty to adhere to the following guidelines in their professional relationships with non-physician personnel whom they supervise, direct, or delegate acts which constitute the practice of medicine and surgery:

Guidelines for Direction, Supervision and Delegation to Non-Physician Personnel

I. Every physician who directs, supervises or delegates acts which constitute the practice of medicine and surgery to non-physician personnel should:

(a) be actively engaged in the practice of medicine and surgery in Kansas;

(b) establish a process for the initial and periodic evaluation of the professional competency of such personnel;

(c) annually review any written practice protocols between the physician and such personnel;

(d) direct, supervise or delegate to such personnel only those acts which constitute the practice of medicine and surgery which the physician believes such personnel is competent to perform, based on not less than 30 days practice under the immediate direction and supervision and in the physical presence of the physician;

(e) direct, supervise or delegate only those acts which are within the normal and customary specialty, competence and practice of the physician;

(f) review all patient records of patients treated by such personnel and document such review in the patient record;

(g) provide for a substitute physician to direct and supervise such personnel when the physician is temporarily absent or unavailable by telecommunication;

(h) periodically see patients at the same location with such personnel at a minimum of 24 days each year;

(i) provide that non-physician personnel should be identified as such to patients;

II. No physician should direct, supervise or delegate acts which constitute the practice of medicine and surgery to more than two non-physician personnel simultaneously;

III. If arrangements to direct, supervise, enter into practice protocols, or delegate acts which constitute the practice of medicine and surgery to non-physician personnel are inconsistent with these guidelines and designed primarily to satisfy or circumvent existing legal requirements, a physician should not receive any fees or other compensation;

IV. Notwithstanding these guidelines, physicians should adhere to any applicable laws governing the professional relationships between physicians and non-physician personnel, and be it further

Resolved, That the Executive Committee be asked to continue the Task Force on Practice Issues for another year in order to further discuss and refine the concepts contained in this resolution, and be it further

Resolved, That the concept of a quality assurance program for the use of non-physician personnel be referred to the Task Force on Practice Issues for study and recommendation.

RESOLUTION 96-13

Commendation for Lew Purinton, M.D.

Whereas, Lew Purinton, M.D., has, for more than 40 years, devoted his energies to the practice of medicine in Kansas; and

Whereas, His faithful presence and leadership in the Kansas Medical Society Executive Committee and Council has benefitted both the profession and the public; and

Whereas, He has served Kansas medicine with distinction on the national level as Alternate Delegate and Delegate to the American Medical Association for more than 20 years; and

Whereas, This series of accomplishments have brought great credit to the Kansas Medical Society and to the medical profession; therefore be it

Resolved, That the Kansas Medical Society present to Lew Purinton, M.D., this resolution of commendation for his years of devoted service to the profession.

RESOLUTION 96-14

American Cancer Society Mobile Classroom and Health Education Initiative

Whereas, The American Medical Association acknowledged that, "It is the growing belief that any future advances made in improving the nation's health will not result from spectacular biomedical breakthroughs. Rather, advances will result from personally initiated actions that are directly influenced by the individual's health-related activities, beliefs, and knowledge. School health education can make a valuable contribution in areas such as these and can play an important role in improving the quality of living;" and

Whereas, The American Cancer Society has adopted the development and enactment of comprehensive school health education as one of its core goals for the year 2000; and

Whereas, The Kansas Division of the American Cancer Society has developed a mobile classroom to provide an action oriented learning experience to teach Kansas youth that good nutrition and healthy living habits are essential to a healthy body and strong mind; therefore be it

Resolved, That the Kansas Medical Society endorse the mobile classroom and encourage its members to work with the American Cancer Society to promote the mobile classroom and health education in their communities throughout Kansas.

RESOLUTION 96-15

Patient-Physician Covenant

Whereas, Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally obligated to act as advocates for the sick, injured or infirm wherever their welfare is threatened and for their health at all times; and

Whereas, By its traditions and very nature, medicine is a special kind of human activity — one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest; therefore be it

Resolved, That the Kansas Medical Society adopt the following covenant between the physician and patient:

A physician's first obligation must be to serve the good of those persons who placing the patient's well-being first and foremost may compromise quality or jeopardize access to medical care.

The medical profession must reaffirm the primacy of its obligations to the patient through national, state and local professional societies, through research, and especially through personal behavior. As advocates for the promotion of health and support of the sick and injured, physicians are called upon to discuss, defend and deliver medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of the profession be affirmed; and be it further

Resolved, That the Kansas Medical Society submit an appropriate resolution to the 1996 AMA annual meeting encouraging the American Medical Association to adopt this covenant of organized medicine's commitment first and foremost to

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patients.

RESOLUTION 96-16

Credentialing and Managed Care Companies

Resolved, That the Kansas Medical Society support the concept of a centralized credentials verification program which could provide services to managed care plans and hospitals statewide.

RESOLUTION 96-17

Military Service Members

Whereas, Continued involvement by U.S. military troops in overseas peacekeeping efforts affects those physician members with military obligations; and

Whereas, Those individuals in the reserve capacity are faced with an almost immediate temporary closure of an office practice; therefore be it

Resolved, That section 1.6123 of the KMS bylaws be amended by inserting the following language and deleting the original language so that the new section will read as follows:

1.6123 Military Service-Reserve — Any member reservist called into service in a full-time active duty capacity with the armed forces may be exempt from payment of all or part of membership dues at the discretion of the Executive Committee; and be it further

Resolved, The section 1.6128 of the KMS bylaws be amended by inserting the word "Active" after the word "Service" so that the section will read as follows:

1.6128 Military Service-Active — Physicians on full-time active duty with the military service. They shall pay fifty per cent (50 percent) of the regular KMS dues and assessments. They shall have the right to vote, but will not be eligible to hold office.

RESOLUTION 96-18

Release of Child Immunization Records

Whereas, Immunizations play a major role in the health of children in this country; and

Whereas, Complete immunization records are required when children enter Kansas schools; and

Whereas, Producing complete records can create a severe burden to parents, schools, child and day care facilities, health departments and physicians' offices when parental consent is required each time a record is released; and

Whereas, During the 1996 Kansas legislative session, consideration was given to a bill which would permit the release of child immunization information to certain facilities needing such information without the parent's written authorization; and

Whereas, The passage of this type of legislation appropriately written would be in the best interests of the child, parents, schools, physicians and other entities needing this information; now therefore be it

Resolved, That the Kansas Medical Society go on record in support of the law enacted by the 1996 legislature allowing the release and sharing of childhood immunization information, and encourage the legislature to extend its provisions to private schools.

RESOLUTION 96-19

Infectious Disease Control Programs

Whereas, The Kansas legislature enacted HB 2586 which was designed to limit the exposure of persons working in law enforcement and emergency services to a specific life threatening infectious disease. This goal was to be accomplished through court ordered testing of persons arrested, charged or convicted of crimes and through the disclosure, reporting and sharing of related information; and

Whereas, While the intent of this legislation is meritorious, it failed to accomplish the development of a realistic

prevention program which would include other life threatening infectious diseases and extend the program provisions to all persons involved in the handling or caring for this identified group of persons; therefore be it

Resolved, That the Kansas Medical Society work with appropriate law enforcement, health and other involved organizations to develop a medically sound and realistic infectious disease prevention program; and be it further

Resolved, That the KMS Legislative Committee be directed to develop appropriate amendments for introduction in the next legislative session to accomplish these objectives.

RESOLUTION 96-20

Workers Compensation Program

Whereas, Current Kansas statute (K.S.A. 44-510e subparagraph a) provides that job task analysis (application of physician determined work restrictions) under the Kansas Workers Compensation Program is to be performed by a physician; and

Whereas, The medical profession concurs that evaluation, determination and assignment of work related restrictions must remain a physician responsibility; and

Whereas, Some physicians believe that the performance of job task analysis can be performed by non-physicians who possess the appropriate skills and training under the direction of a physician; therefore be it

Resolved, That the Kansas Medical Society review this matter with the director of the Kansas Workers Compensation Program; and be it further

Resolved, That if deemed necessary, KMS draft and request introduction of appropriate legislation which would permit job task analysis to be performed by non-physicians possessing the needed skills and training under the direction of a physician.

RESOLUTION 96-21

Reporting of Substance Abuse

Whereas, Health care providers are required to report certain injuries and illnesses to the appropriate law enforcement agency (e.g. gunshot wounds, stab wounds, assaults, reportable diseases); and

Whereas, This is recognized as being for the good of society and such reporting is provided immunity from prosecution for violating the doctor-patient confidentiality; and

Whereas, There is no such immunity or protection for the health care provider who recognizes the incapacitation of a driver from substance abuse; and

Whereas, The health care provider may be held responsible for not taking action to prevent this person from driving while under the effects of abusive substances; therefore be it

Resolved, That the Kansas Medical Society draft and request introduction of legislation that would provide immunity from prosecution for health care providers who report the suspicion of substance abuse by persons who have been or can be expected to operate a motor vehicle while under the effects of abusive substance to the appropriate law enforcement agency; and therefore be it further

Resolved, That the Kansas Medical Society support the concept of routine breath analysis of all drivers involved in motor vehicle accidents. This testing would be performed by the investigating officer and thus remove the health care worker from policing for DWI violations.

RESOLUTION 96-22

Student Athletic Examinations

Not adopted

RESOLUTION 96-23

Mandated Medical Screening Examinations

Whereas, The Comprehensive Omnibus Budget Reconciliation Act/Emergency Medical Treatment and Active Labor Act (COBRA/EMTALA) legislation requires that every patient presenting to a hospital based emergency department must receive an adequate medical screening exam to rule out the presence of an emergent medical condition or active labor; and

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Whereas, More and more third-party payors are requesting prior authorization before authorizing treatment at these hospital based emergency departments and are frequently asking that the patient be screened but not treated; and

Whereas, Most third-party payors are refusing to reimburse for this mandated screening exam; therefore be it

Resolved, That the Kansas Medical Society draft and request introduction of legislation which provides that any contract or policy for individual or group accident/health insurance issued in this state and any contract issued by a managed care or health maintenance organization authorized to transact business in Kansas shall reimburse for all physician provided and ordered services which are necessary to conduct the medical screening examinations and stabilizing treatment required pursuant to Section 1867 of the Social Security Act.

RESOLUTION 96-25

Associate Membership Requirement for KaMMCO and Heartland Health

Not adopted; combined with 96-11.

RESOLUTION 96-26

Physician Involvement in the Dying Process

Whereas, Assisted suicide is the intentional advising, encouraging or assisting another person in the taking of his or her own life, which is illegal in Kansas; and

Whereas, Support, comfort, respect for patient autonomy, good communication, and adequate pain control are essential elements of the physician's role in the care of patients in the end stages of life; and

Whereas, Decisions near the end of life should be made by the patient and family in consultation with their physicians and other family advisors or counselors; therefore be it

Resolved, That it is the position of the Kansas Medical Society that;

1. Physician assisted suicide is fundamentally inconsistent with the physician's professional role;
2. The principle of patient autonomy requires that physicians must respect the decision to forego life-sustaining treatment by patients who possess decision-making capacity;
3. There is no ethical distinction between withdrawing and withholding life-sustaining treatment at the patient's request;
4. Physicians who care for patients with terminal illnesses should seek to educate themselves about advanced pain management techniques;
5. Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care, including providing palliative treatment even though it may foreseeably hasten death; and
6. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should not decrease.

RESOLUTION 96-27

Violence in Kansas and the United States

Whereas, Violence is increasing in Kansas and the U.S.; and

Whereas, Violence is one of the state's greatest threats and the largest cause of disability; and

Whereas, The death toll from guns due to homicide and suicide in the U.S. in 1992 was 35,959. The death toll from auto accidents in 1993 was 44,000. The number one causes of brain injury deaths are firearms and auto accidents; and

Whereas, The social, economic and human costs of caring for those left disabled by violence is incomprehensible: $1.4 billion for 3000 spinal cords per year; and

Whereas, Incarceration is not working to decrease violence and crime in our society and is very expensive: $55 billion per year for implementation for "3 strikes and you're out" in California. Texas has executed convicts more efficiently than any state, yet its murder rate remains one of the nation's highest; and

Whereas, Criminal justice institutions are now public health agencies; and

Whereas, Prevention is the main antidote to decrease violence

and crime; and

Whereas, The Injury Registry was established by the CDC to track hows, whys and results of violence and get accurate statistics; and

Whereas, Both Kansas and Missouri federal senators have declared this "too much government" and vowed to eliminate the registry funding, $2.3 million per year; therefore be it

Resolved, That KMS encourage Kansas physicians and promote the Kansas Death and Injury Secondary to Violence Registry by working toward identifying acts of violence, reasons and means of violence and address prevention of those acts.

RESOLUTION 96-28

Peer Review by State Disciplinary Agencies

Whereas, Physicians are expected and required to make decisions which have dramatic importance for patients whom we serve, especially those at the end of life; and

Whereas, Many decisions physicians make on behalf of their patients are of such complexity that only other physicians are capable of conducting an adequate review of the appropriateness of such decisions; and

Whereas, Various state disciplinary and law enforcement agencies should have a process for obtaining qualified peer review prior to proceeding with prosecutions in complex cases; and

Whereas, A recent court ruling has the potential of creating a precedent of criminalizing negligence, thus placing physicians in jeopardy for making difficult patient care decisions, especially involving end of life issues; therefore be it

Resolved, That the Kansas Medical Society initiate a dialogue with the Kansas State Board of Healing Arts, the Kansas Attorney General and other appropriate agencies to discuss the importance of obtaining qualified peer review prior to making a decision to prosecute cases which involve complex medical decisions, especially in dying patients; and be it further

Resolved, That the Kansas Medical Society also express its grave concerns over the criminalizing of clinical negligence. KMS

Council District reports to the 1996 House of Delegates

Council District 1

The annual district meeting was held in Atchison in October, 1995. Representatives from all three component medical societies including Northeast Kansas, Atchison County and Leavenworth County were present. This meeting hosted our Kansas Medical Society (KMS) President, Dr. Linda D. Warren. Topics discussed included Heartland Health, improving communication with the University of Kansas Medical School, development of a Western Kansas KMS field office which would be shared by KaMMCO, recruitment of new physician and medical student members, and the general state of affairs of medicine in the Northeastern medical corridor. Elections were held and Dr. Vernon A. Mills replaced retiring councilor, Dr. John R. Eplee. Dr. A.K. Tayiem assumed the post of alternate councilor.

As a member of Heartland Health Board of Directors, I gave advice and supported the development of a statewide physician network and insurance company that would be responsive to physicians, patients, and market needs. Heartland's Medicaid managed care product, Horizon's PrimeCare, will be offered in District 1 this fall.

There have been successful efforts in the district to improve access to health care in the rural counties by initiating rural health care clinics. Physicians in the Northeast Kansas Medical Society report very good community support for local physicians' efforts to provide needed care.

In Leavenworth County, there have been significant efforts by hospitals and insurance companies to organize physicians, and although managed care has made significant market penetration, most physicians remain in private practice. Many of the county physicians are becoming more economically and politically aware and becoming significant advocates for their patients and their medical practices.

Vernon A. Mills, MD, Councilor

COUNCIL DISTRICT 3

The focus of the Johnson County Medical Society continues to be on the following projects: Annual Legislative Dinner, Annual Legislative Breakfast, Physician Preceptor Programs, Healthy Kids Council, and quarterly general meetings.

The Healthy Kids Council planned a day of continuing education for school nurses, teachers, social workers, and counselors on Thursday, August 3, at the Johnson County Community College. The Healthy Kids Council is a coalition of the Johnson County Medical Society and its Alliance, the Johnson County Community College, the county hospitals, schools, and the health department. Their mission statement is "striving for solutions to healthcare challenges of Johnson County youth."

The Annual Legislative Dinner was held at the Overland Park Doubletree Hotel. The speaker was Christian Hageseth, MD. The Legislative Breakfast, hosted by the Mid America Rehabilitation Hospital, was a roundtable forum with the physicians and legislators.

A Physician Preceptor Program was held conjointly with Metropolitan Medical Society. Tom Williams, MD, continues as the chairman of the program.

Regina Nouhan, MD, and Jeremy Baptist, MD, were judges for the Greater Kansas City Science Fair. William McEachen, MD, presented certificates and prizes to the first and second place entries under the name of "The Physicians of Greater Kansas City." Johnson County, Metropolitan Medical, and the Jackson County Osteopathic Societies each provided two judges for the biological division of awards.

Linda Warren, MD, President of KMS, and Lisa Barker, President of the KMS Alliance visited Wyandotte and Johnson Counties in February.

The Office Personnel continues to meet on the fourth Tuesday over lunch in an area restaurant. Roundtable group discussions are held regarding pertinent topics in healthcare.

Our President is Tom G. Sullivan, MD.

Lawrence D. Riffel, MD, Councilor

COUNCIL DISTRICT 4

This district consists of three independent county medical societies: Bourbon, Crawford-Cherokee, and Labette. Bourbon County Society meets in Fort Scott and Mark Carlson, MD, is President; Crawford-Cherokee County Society meets in Pittsburg with Kathleen Sandness, MD, as President; and Labette County Society meets in Parsons with Radha Pai, MD, as President.

Each of the societies meets for the primary purpose of conducting continuing medical education activities. The Crawford-Cherokee and Labette County Societies meet monthly, while the Bourbon County Society meets every other month.

Several physicians from the Labette County Society have been active in the Kansas Medical Society, serving on the Council, various committees, and one serving as AMA delegate. The Labette County Society has also provided scholarship funds for the local nursing program at Labette Community College. The physicians of the Crawford-Cherokee County Society continue to monitor the local ambulance service, providing review and evaluation functions.

Daniel N. Pauls, MD, Councilor

COUNCIL DISTRICT 5

Our educational program at the April, 1995 meeting of the Society was presented by Tom Norton, Vice-President, Government Affairs, Searle Labs. His presentation was entitled, "The Aftermath of Healthcare Reform."

At the May 1995 meeting, Jeff Curtis, MD, gave a "Cardiovascular Update." Bob Cathey, M.D., presented the Councilor's report. The annual Riley County Medical Society picnic was held on Saturday, June 24, 1995, at the Optimist Park here in Manhattan.

The annual visit of the KMS President, Linda Warren, MD, and the KMSA President, Lisa Barker, was the highlight of our October meeting. In November, the Society sponsored a trip to Topeka to see the Treasures of the Czars.

At the January, 1996 meeting Debra Doubek, MD, was elected President of the Riley County Medical Society; Douglas Foulk, MD, was elected Vice-President and Donald Huang, MD, was elected Secretary-Treasurer.

The February educational program was presented by Stephen A. Chartrand, MD, "Facing the Challenge of Microbial Resistance: The Respiratory Tract."

In March of this year, a slide presentation, "A Medical Mission to Russia," was given by our own Anne Wigglesworth, MD, Eugene A. Klingler, MD, Earlene Gould, C.R.N.A., and Gay May, RN. In April, Doctor Jim Gardner, MD, was elected as Councilor of District 5.

Robert H. Cathey, MD, Councilor

COUNCIL DISTRICT 6

This is my first annual report for the KMS Council. I have fully enjoyed my year as the district councilor and am looking forward to the coming year.

This has been a year of change for Shawnee County Medical Society and the change is ongoing. In spite of the change, we have been able to continue with many of our

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community activities.

Our annual meeting was in June and was again held in Ward Meade Park. KMS President, Linda Warren, MD, was the guest of honor and the primary speaker. The park is of special interest because the Society is a joint sponsor with Ward Meade and the Shawnee County Dental Association in the construction of a turn-of-the century drugstore, soda fountain and pharmacy. A physician and a dentist office are also a part of the building. The project is progressing satisfactorily with much of the structure now open to the public.

SCMS sponsored two seminars titled, "Coping With Stress" and "Change in the Medical Office." The seminars were presented by Jerry Johnson in November and February. The events were open to physicians, their spouses and employees. The response of those attending was excellent.

The Summer Fiesta was in July. This was a social evening that was jointly sponsored by Shawnee County Medical Society and the Medical Alliance. The event was held at the home of Dr. S.K. and Sue Gandhi. There was a good turnout and everyone enjoyed themselves. The Senior Section continues to meet the second and fourth Friday of each month for coffee and doughnuts. The group has been extremely supportive of recruiting residents into membership in the society. The meetings have again proved to be a source of genuine satisfaction for the members of the section.

As in past years, SCMS has been a sponsor for the National Youth Sports Program at Washburn University. We are represented on the advisory board, and society members provided free physicals to over 200 underprivileged youths who meet federal poverty guidelines.

SCMS has actively supported the Race Against Breast Cancer. There is a representative of the society on the Board of Directors and the Society has assisted in many RABC activities through the year. We were co-sponsors of Breast Cancer Awareness Month (October) and helped bring Marcia Wallace, a breast cancer survivor and actress, to Topeka for a presentation. The society co-sponsored the annual race and presently is donating office space for the official RABC office.

In October, the Society helped bring Robert Keeshan, TV's Captain Kangaroo, to Topeka for a presentation. This was a part of our support for the Governor's Conference on Child Abuse.

The Women's Section of SCMS co-sponsored the annual program, "What Do You Want To Be When You Grow Up?" Members staffed a booth at the program/meeting, where literature was available and young people interested in becoming physicians were able to ask questions.

In cooperation with Shawnee County Health Department and other community agencies, the Society has worked on the Immunization Task Force. This group works to plan and present the annual Immunization Day in the community.

Significantly, Shawnee County Medical Society has been engaged in a reorganization process this year. The membership voted to reduce dues dramatically. This has necessitated a number of changes which will clearly affect the activities of this society. Our Executive Director, Byron Cook, left the organization and the board is struggling with ways to reduce overhead to meet the budget provided by the current dues. A special broad based committee of the membership has been formed to revise the mission and objectives of the society. It is a turbulent time but we are optimistic that the society, with new direction, will be better able to meet the needs of the membership.

Thomas Coolidge, MD, Councilor

Council District 7

Since my election there have been no major changes in the medical community. The election of officers is as follows: Herbert Brahman, MD, President; Norman Fordyce, MD, Secretary/Treasurer; and Michael L. Montgomery, MD, Program Director.

Linda Warren, MD, President of the Kansas Medical Society, was the guest-speaker at the November, 1995 Council District meeting.

Nelson P.H. White, MD, Councilor

Council District 8

Activity this past year has been highlighted by the visit in September of 1995 by our KMS President, Linda Warren, MD, from Hanover. Dr. Warren explained the objectives and items of her agenda for the new year and also several aspects of the legislative program.

A highlight of the meeting was a visit from Mrs. Lisa Barker, KMSA President. She outlined her program for the coming year and the appropriateness of developing new programs. One of the most pressing issues is membership and participation.

The Cowley County Medical Society holds monthly meetings and has a Scientific Program sometimes sponsored by the University of Kansas School of Medicine-Wichita. Also, some

of our programs have been sponsored by pharmaceutical companies. We are striving to enroll every physician in Cowley County, but so far have not been successful. We do have several members that are members of the AMA. Arkansas City has been working diligently to recruit new physicians. We do have some consultants from Wichita and Ponca City, Oklahoma. We are now working on building a Dialysis Unit next to our local hospital and this will be manned by a Nephrology group from Wichita.

The Snyder Clinic in Winfield has added some new physicians recently and the hospital had a full-time psychiatrist on board as of June 1995.

Participation in the Heartland Health Network is moving forward with credentialing, and we are all looking forward to a great relationship.

Newton C. Smith, MD, Councilor

COUNCIL DISTRICT 9

In October of 1995, after months and even years of negotiation and work, both of Salina's hospitals (formerly Asbury Regional Medical Center and St. John's Hospital) have merged to form the Salina Regional Health Center. Both hospital sites continue to be utilized and are designated as the Santa Fe Campus and Penn Campus. While the type of services that will be offered at each site is still under evolution, the Santa Fe Campus presently handles all of the inpatient admissions, surgery, and emergency services while the Penn Campus offers ambulatory services, skilled nursing and respite care.

Also in October of 1995, the Santa Fe Medical Plaza office building was opened and occupied. It is located directly across the street from the Santa Fe Campus. The new residents include the Salina Clinic, Smoky Hill Family Practice Residency Program, Salina Urology Associates, the Orthopedic Clinic of Salina, Salina Regional Health Center Outpatient Physical Therapy, and Physical Medicine and Rehabilitation.

In the last year, the Smoky Hill Family Practice Residency Program has graduated five residents and all of these physicians will remain in Kansas to practice. The program has been in existence now since 1978 and is approved for all three years of family practice training. Since its establishment, over 70 percent of all graduates have remained in Kansas, mostly serving rural areas of Kansas. All of the graduates have become board certified in family practice.

The North Central Kansas PHO is now into its second year of operation. It was established in February of 1995 and has recently hired Mr. Ivan Gatenbien as the Director. Mr. Gatenbien is presently working to structure products to market for the PHO. Presently, there are 16 hospitals and approximately 90 physicians associated with the North Central Kansas PHO.

Alan L. Kruckemyer, MD, Councilor

COUNCIL DISTRICT 10

District highlights included a visit from KMS President, Linda Warren, MD; her husband, Roger Warren, MD; Mrs. Lisa Barker, President of KMS Alliance; and Ms. Carolyn Price of the KMS staff, at the Old Mill Restaurant in Newton in November, 1995. Issues of interest to physicians and their spouses were discussed.

Throughout the remainder of the year regular medical society meetings have been held in Harvey and Reno Counties, in conjunction with the hospital quarterly staff meetings. Issues of interest include construction of a new Newton Medical Center and proposed sale of Halstead Hospital to Columbia.

Kenneth Kimmel, MD, Councilor

COUNCIL DISTRICT 11

The activities of the Medical Society of Sedgwick County continue to increase in terms of both numbers and complexity. The MSSC's membership at the end of 1995 totaled 975, of whom 801 are actively practicing physicians.

During the year, considerable energy and funds have been expended in efforts to develop a cooperative Medicaid managed care program (CCK) involving the four Wichita hospitals, as well as hospitals and physicians in Bourbon, Finney and Montgomery counties. Final negotiations between CCK and the State Department of Social and Rehabilitation Services are now being considered by Governor Bill Graves.

Through the Earl Mills Trust, established in the memory of Dr. Earl Mills, a high level medical educational seminar is being planned. The program, being coordinated through University of Kansas School of Medicine-Wichita and the other responsible trust entities, will be held during October, 1996, to which all Kansas physicians will be invited.

The MSSC is participating in a community health needs assessment program being carried out by Wichita State University School of Health Sciences, University of Kansas School of Medicine-Wichita, and the Wichita/Sedgwick County Department of Community Health, and funded through

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the Kansas Health Foundation. This program is to identify unmet needs, available resources and to develop recommendations concerning how the identified needs can be resolved.

Following the Oklahoma City bombing disaster, many of the MSSC members contributed to the Disaster Relief Fund coordinated by the Oklahoma County Medical Society.

In cooperation with the area pharmacists, the "Pharmacy Hotline" was reorganized in 1992, whereby information can be distributed to all area pharmacies within ten minutes. During 1995, 114 potentially fraudulent situations were disseminated.

Other day-to-day activities related to Emergency Medical Services, Medical Careers Loan Fund, Medical Student Emergency Loan Fund Program, Medical Service Bureau, Physician Paging System, Physician Information Verification Program for area hospitals and managed care programs, Legislative Issues, SedgPAC, Medical Review Foundation, WPPA, Employee Assistance and Behavioral Health Care Management, and the Sedgwick County Health Care Cost Containment Roundtable.

James A. Loeffler, MD, Councilor

Council District 13

Dr. Linda Warren addressed the CKMS membership at our fall meeting in October, 1995. Current events and issues regarding Heartland Health marketing efforts as well as other state and national events were discussed.

The medical community of the CKMS area continues to grow as more new physicians have entered the community in the last year. Physicians were recruited in the disciplines of neurology, family practice, internal medicine, and pulmonary and infectious diseases.

CKMS continues its long term commitment to support Fort Hays State University by funding support for pre-med student scholarships.

During the fall meeting in October, 1995, new officers were elected. Officers are Dr. Donald Tillman, President; Dr. John C. Pokorny, Vice-President; and Dr. Cindy Brenner, Secretary/Treasurer. District Representative Greg Woods, MD, and Howard Wilcox, MD, were selected to attend the Annual Meeting in May 1996.

Ward M. Newcomb, MD, Councilor

Council District 14

The Barton and Pawnee County Medical Society held its annual meeting in June, 1995 at the Great Bend Petroleum Club. Richard Preston, MD, was re-elected President, and Perry Schuetz, MD, continued in his term as Councilor. Perry Smith, MD continues as Secretary/Treasurer.

The highlight of the meeting was the address by newly-elected KMS President, Linda Warren, MD. This was one of her first outings in her presidential role, and she was a great hit.

Most of the physicians of Barton-Pawnee counties are shareholders in Heartland Health. There is much discussion locally of forming an HMO in conjunction with the Central Kansas Medical Center. Integrating Heartland Health into this plan is a current topic of much local interest.

Although several new physicians have come into our counties, there still remain some shortages in primary care. David Wahbeh, MD, in pediatrics; Bill Slater, MD, in general surgery; Robin Durrett, DO, in general surgery; and Nehal Masood, MD, in family practice, are some of our new physicians. Bill King, MD, retired in the past year while in good health and is getting a chance to do those things we are all putting off. John Edmonds, husband of Marta Edmonds, MD, is our local state representative and has been a good friend of medicine.

Perry N. Schuetz, MD, Councilor

Council District 18

Council District 18 met in March, 1996 at the University of Kansas Alumni Center in Lawrence, Kansas, with representation of surrounding counties. The President of the KMS Alliance, Lisa Barker, and Dr. Linda Warren, President of KMS, gave reports of progress of the Alliance and the Kansas Medical Society.

The Lawrence Community Health Plan, a joint effort between the physicians of Lawrence Memorial Hospital staff and the hospital, provides

The highlight of the meeting was the address by KMS President, Linda Warren, MD. . . . She was a great hit!

Perry Schuetz, Councilor
Council District 14

an insurance product and is now in full swing and continues to grow and become more competitive. There is a very competitive market in Douglas County with the addition of three HMOs and numerous PPOs and other insurance programs. Competition is intense and the physicians are feeling a tremendous pressure of insurance companies having control over our patients. This trend is obviously going to increase and the concern of most physicians is growing in regard to what the future holds.

The Lawrence Memorial Hospital made a decision not to enter into a sale contract with Columbia or any other health care providing group at least at the present time. The hospital has made a marvelous new expansion and remains profitable and competitive, while at the same time Columbia has been threatening to build a second hospital in Douglas County. Columbia has purchased at least two physician groups in Douglas County and it appears to be interested in a third group. All in all, the entire medical market of Douglas County is highly competitive and physicians are being swept along in the current.

Phillip A. Godwin, MD, Councilor

A moment of silence . . .

Stuart C. Averill, MD

Dr. Averill, 72, a Topeka psychiatrist and past director of the C.F. Menninger Memorial Hospital, died August 8, 1996 in Topeka.

Dr. Averill, who was recently named director of the psychoanalytic clinic at the hospital, spent 18 years as clinical director of the Boys Industrial School.

He was born May 31, 1924 in Sacramento, California and grew up in Dixon, California. He attended John Hopkins University and took a leave for three years to serve in the U.S. Navy. He returned to California and was graduated from the University of California at Berkeley and the University of California Medical School.

He married Elizabeth "Tucker" Walter in 1946. She survives.

Dr. Averill was a member of the First Congregational Church. He was also a past president of the Shawnee County Medical Society and held memberships in the Kansas Medical Society, the American Psychiatric Society, and the American Psychoanalytic Society.

Paul B. Burger, MD

Dr. Burger, 71, a Shawnee family physician, died June 28, 1996.

He was born in Kansas City, Kansas and lived in the area most of his life. Dr. Burger graduated from St. Louis University Medical School and went into private practice. He was on staff at Shawnee Mission Medical Center and courtesy staff at Providence Medical Center.

His wife of 47 years, Donna, survives.

Dr. Burger was past president of the St. Mary's Hospital Staff and served as the Shawnee Police Department physician until his death. He received the Kansas Monk Award from St. Benedict's College in 1968. Dr. Burger was a member of the Kansas Medical Society and a past president of Kansas Right to Life.

Courtney Clark, MD

Dr. Clark, 66, a Wichita anesthesiologist, died July 27, 1996. He is survived by his wife, Katharine.

David R. Davis, MD

Dr. Davis, 93, an Emporia pediatrician, died August 3, 1996.

He was in general practice from 1930 until his retirement in 1978. He practiced medicine in the farm communities around Olpe, Kansas.

Dr. Davis received his medical degree from Tulane University in New Orleans. He served his internship at Kansas City General Hospital and Children's Mercy Hospital in Kansas City, Missouri.

He was a U.S. Navy veteran of World War II, and a member of the Navy Reserve until he retired in 1963 with the rank of captain.

Dr. Davis married Dorothy L. Jennings in 1929. She preceded him in death in 1993.

He was a member of the Westminster Presbyterian Church and a charter member of the DeMolay and Blue Lodge. He was past president and member of the board of the American Academy of Pediatrics, past president of the Flint Hills Medical Society, staff member emeritus and president of Newman and St. Mary's hospitals, and chairman of the Child Welfare Committee of the Kansas Medical Society.

He was also active with the Boy Scouts of America, the Emporia Chamber of Commerce, Emporia Youth Camp, Camp Alexander, the

College of Emporia, Aberdeen Angus Association, American Legion, Lions Club, and the Outlook Club.

Calvin W. Henning, MD

Dr. Henning, 90, a retired Ottawa physician, died May 29, 1996 in Topeka.

He received his medical degree from Kansas University Medical School in 1935.

Henning set up a medical practice with his brothers in 1936. He retired in 1986 after 50 years of practice in Ottawa and remained there until entering a Topeka nursing home in March 1995.

Dr. Henning married Luella A. Downing in 1931. She preceded him in death in 1973. He then married Betty Silvius in 1976. She survives.

He was a member of Kiwanis for over 50 years, had served as Kansas lieutenant governor and was one of only four Kansas Kiwanians ever to be named a Hixson Fellow. He was also a member of the American Medical Association, the Kansas Medical Society, Franklin County Medical Society, Masons, and Lawrence Scottish Rite.

Herbert H. Hesser, MD

Dr. Hesser, 89, a retired Overland Park surgeon, died May 7, 1996.

He was born July 31, 1906 in Kansas City, Kansas and he lived there most of his life. He graduated from the University of Kansas School of Medicine in 1934. After serving an internship at St. Margaret Hospital, he engaged in the practice of family medicine before entering training in surgery at the University of Pennsylvania, where he received a Masters degree.

His wife of 58 years, Amelia S. Hesser, survives.

Dr. Hesser was a diplomat of the American College of Surgery and was a Fellow in the American College of Surgeons. He was a member of the Kansas Medical Society, the Armourdale Masonic Lodge #271, the Scottish Rite Masonic Bodies, and the Abdallah Shrine.

Charles S. Joss, Sr., MD

Dr. Joss, 82, a retired Topeka surgeon, died June 24, 1996.

He was born February 20, 1914 in Topeka. He received his medical degree from Northwestern University Medical School in 1940. He was a Fellow in surgery at the Mayo Foundation in Rochester, Maine for two years, before entering the U.S. Army in 1942 as a medical officer. He was discharged in 1945. Two years later, he returned to Topeka and established a surgical practice with his father.

Dr. Joss was married to Doris Firestone. She preceded him in death in 1995.

He was past president of St. Francis Medical Staff, and a member of the Shawnee County Medical Society and Washburn University Board of Regents. He was also a member of the Kansas Medical Society, American Medical Association, and the Southwestern Surgical Congress.

Raymond A. Schwegler, MD

Dr. Schwegler, 88, a retired gynecologist and University of Kansas professor, died July 16, 1996 in Lawrence.

He practiced medicine in Lawrence until 1956, and he later served as the medical director of the Student Health Services at the University of Kansas. He was also a clinical professor of obstetrics at the University of Kansas Medical Center.

Dr. Schwegler received his medical degree and his PhD in anatomy from the University of Minnesota.

He married Alice Josephine Wilson in 1935. She survives.

Dr. Schwegler served in the Army Medical Corps as a major during World War II.

He was a member of AOA Honorary Society and he served on the financial advisory board of the Bert Nash Mental Health Center. He was also a member of the Kansas Medical Society, the Douglas County Medical Society, the American College of Surgery, the Central Association of Obstetrics& Gynecology, and the American College of Obstetrics. He also served on the board of the Douglas County Health Department.

Dr. Schwegler was a 32nd Degree Mason and a member of the Old and New Club and Trinity Episcopal Church.

Chester E. Scott, MD

Dr. Scott, 72, a retired Salina family physician, died June 3, 1996.

He was born July 3, 1923 in Peabody and had been a resident of Salina since 1952. Dr. Scott practiced medicine in Salina for 36 years.

Dr. Scott's wife, Marie Ellen, survives.

A moment of silence

Continued from page 71

He was a Navy Veteran of World War II. He was also a member of the Christian Medical and Dental Association, Saline County Medical Society, Kansas Medical Society and American Medical Association. He was a member of Sunflower Lions Club, Fellowship of Christian Athletes, Gideons, Salina First United Methodist Church, and American Academy of Family Physicians.

Louis N. Speer, MD

Dr. Speer, 81, a retired Ottawa general practitioner and surgeon, died June 3, 1996 in Ottawa.

He practiced in Ottawa for 50 years. Dr. Speer was a staff surgeon with the 110th Tactical Reconnaissance Squadron in the Asiatic Pacific area during World War II. He was discharged with the rank of Major in 1946.

Dr. Speer graduated from Northwestern University School of Medicine in 1941 and completed his surgical residency at Jackson County Hospital, now the Truman Medical Center of Kansas City, Missouri.

He was married to Jessie Roberta Davis. She preceded him in death in 1990.

Dr. Speer was a member of First United Methodist Church in Ottawa. He was a member of the Kansas Medical Society, as well as Ottawa Lodge No. 803 of the Benevolent and Protective Order of the Elks, where he was past exalted ruler. Dr. Speer was a charter member of the Flying Physicians Association, American Bonanza Society, OX5 Club, and the Quiet Birdman Club. He was a member of Delta Tau Delta social fraternity and Phi Beta Pi medical fraternity.

Charles L. White, MD

Dr. White, 89, a retired Great Bend general practitioner, died May 17, 1996 in Quincy, Washington.

He graduated from the University of Kansas School of Medicine in Kansas City, Kansas in 1936. He practiced in Great Bend for 26 years and moved to Quincy in 1989.

Dr. White was married to Madaline S. Harrison. She preceded him in death in 1980.

He was a past president of Kansas Academy of Family Physicians and Kansas Association of General Practitioners, as well as a life member of the Masonic Lodge and Elks Fraternity.

Frederick P. Wolff, MD

Dr. Wolff, 75, a retired internal medicine physician, died June 19, 1996.

He worked in Pratt for 40 years until he retired in 1988. He was a partner in the Black-Wolff Clinic and was Pratt's health officer for 34 years. Dr. Wolff was a past president of the staff of Pratt Regional Medical Center and started one of the first coronary care units in the state. He started Pratt's home health program and also started a five-county hospice in 1988.

He received his medical degree from the University of Kansas Medical School.

He served in the U.S. Army Reserve and Naval Reserve during World War II and the Korean War.

Dr. Wolff was married to Elizabeth Jane Drohan. She preceded him in death in 1993.

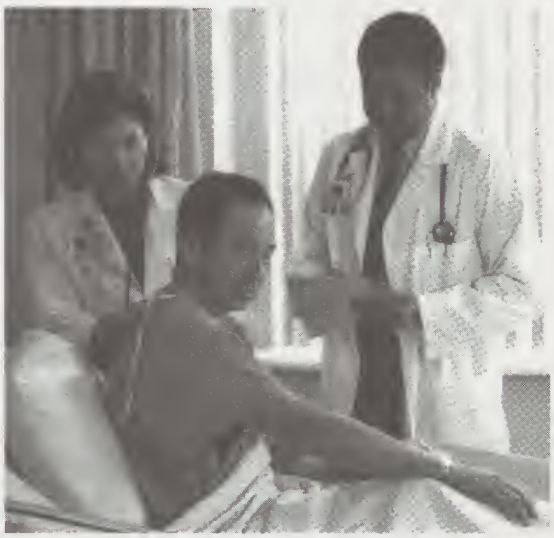
He was a member of the Methodist Church and a charter member of the Church of the Resurrection. He was active in the Boy Scouts of America and belonged to many civic organizations, including the VFW, American Legion, Elks, and Rotary Club. He was president of both the Optimist Club and the Jaycees.

Dr. Wolff was a member of the Kansas Medical Society. He was state president of both the Kansas Society of Internal Medicine and the Kansas Health Officers Association. He was on the boards of the local heart, cancer, arthritis, polio, and lung associations. He also served on several national committees for the American Society of Internal Medicine. KMS

The American Medical Association
Organized Medical Staff Section

Caring doctors.

You want the best for your patients. You give them the kind of attention and quality care they deserve and they trust you with their lives. This is the patient-physician relationship you want to protect.



Part of managed care.

As a participant in a managed care plan, you still give your all for your patients and want to provide the highest quality care. But the patient-physician relationship you value is facing some special challenges. The health care environment is changing and so are the rules.

Shaping the future of health care.

You can help formulate those rules and take an active role in the future of your profession as a part of the AMA Organized Medical Staff Section (OMSS).

This section is an expansion of the Hospital Medical Staff Section. It now embraces the growing number of physicians in managed care. The OMSS offers assistance, representation, and a strong, unified voice within these organized settings.

The OMSS is a forum for identifying and initiating policy on issues including: fairness and due process rights, continuous quality improvement, peer review, resource/utilization management, ethics, and leadership.

Any medical staff of a hospital, integrated delivery system, or health care plan may designate an OMSS representative, who must be an AMA member with active medical privileges. Each staff has one vote — an equal voice, regardless of size.

If you are interested in designating an AMA OMSS representative and/or attending an upcoming meeting, call **800 AMA-3211** and ask for the AMA Department of Organized Medical Staff Services.

We cannot begin to confront the unique challenges facing us without you. Call **800 AMA-3211** today.

The Voice of Grassroots Physicians.

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Physicians dedicated to the health of America

The last word . . . on managed care

As managed care becomes a "fact of life" in Kansas, what are your feelings about being part of that system?

Physicians still hold the trump card—we're the ones who know how to get the patient well. To ignore managed care is to ignore that one huge advantage we still hold, and to by default pass it on to those whose allegiance may be to an oath that is less than Hippocratic. If we are true to our patients (and thereby to ourselves), we must realize that managed care is just that latest "fact of life" and by no means the last. Never forget—managed care needs us. Our patients need us. Do not sell yourself short, or the welfare of your patient population, by an attitude of invincibility or isolationism.

Roger R. Tobias, MD
Family Practice
Lyons

Scorecard medicine is here to stay. We are at a crossroad regarding who will make medical decisions for our patients. It is time for physicians to unify and retake control of medical decision making. In the past, whenever physicians have been asked to form a firing squad—we formed a circle! We must continue to be advocates for quality patient care. As a physician, I will adapt to the managed care system.

Frank H. Griffith, MD
Ophthalmology
Salina

Technology has driven our healthcare system for the past twenty years. Now the new driver is economics. Although physicians are uncomfortable about this aspect, we owe it to our patients and ourselves to continue to be a major player in the decision making of this system.

Jimmie A. Gleason, MD
Obstetrics & Gynecology
Topeka

I can summarize my feelings about managed care in three words: regret, opportunity, and challenge.

I regret the loss of provider control of the health care system. While I have some knowledge of the market forces shaping the new health care system, understanding is small comfort to my loss of professional autonomy. I now practice knowing my clinical decisions are going to be monitored, constrained, and second-guessed.

Any time major system changes occur, opportunities and challenges arise. We have a good start in Kansas: WPPA with ten year's history and 145,000 covered lives plus Heartland Health with strong statewide grassroots support and synergy. The challenge is to have the vision and staying power to play a significant and/or dominant role in the next decade.

Regret, opportunity, and challenge.

Terry Poling, MD
Family Practice
Wichita

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Winter/Spring
Volume 97, Number 3 & 4

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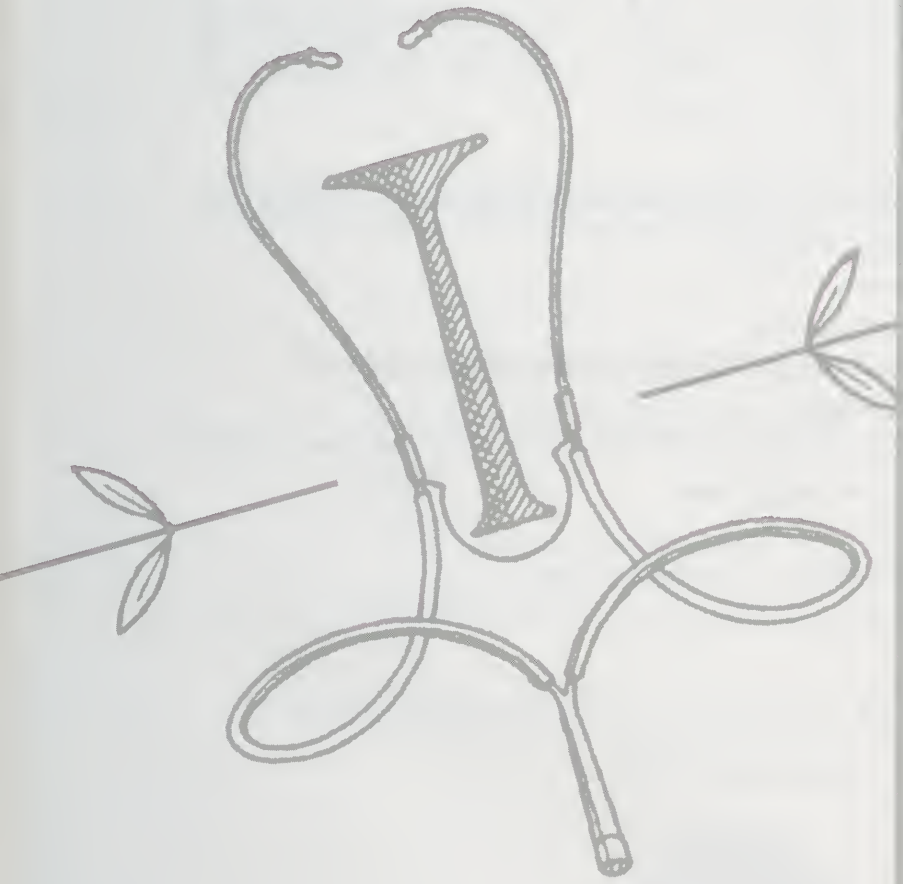

the Journal of the Kansas Medical Society, published since 1901

KANSAS MEDICINE

Winter/Spring
Volume 97, Number 3 & 4

Kansas Medicine (ISSN 8755-0059) is published quarterly by the Kansas Medical Society, 623 SW 10th Ave., Topeka, KS, 66612. KMS membership includes a one-year subscription for which $15 is allocated from each member's dues. Rates to others: $30/year domestic; $45/year foreign. Printed by Graphic Promotions, Topeka, KS. Periodical postage paid at Topeka, KS and at additional mailing offices. POSTMASTER: Send all address changes to *Kansas Medicine*, 623 SW 10th Ave., Topeka, KS, 66612.

Indexed in *Hospital Literature Index* and *Index Medicus*. Available through University Microfilms. Listed in *CC/Clinical Practice*. Search Resource for Institute for Medical Information, Inc., and Medical Search, Inc.

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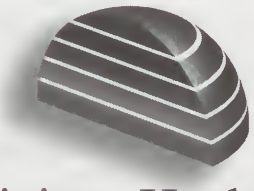

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What's up, doc?

Warren E Meyer, MD

BUGS BUNNY'S PERENNIAL QUESTION directed to Elmer Fudd is also appropriate for today's physicians. Patients are confused and might use the phrase in seeking information from their doctors about the puzzling, topsy-turvy world of health care reform—and what the eventual outcome will mean to their own health care. Physicians themselves may ask this question of their colleagues as they see their world in danger of evaporating around them. At this time, the crystal ball remains clouded (probably due to one of those smoke-filled rooms,) and no definitive path is apparent.

Many things have occurred in the field of health care in recent years, things undreamed of only a few years ago. *Popular Mechanics* had an article on robotics, detailing the way in which the computer can assure the proper insertion of a hip prosthesis better than the physician alone. The CT scan, the MRI, laparoscopic diagnosis and surgery, "robotic surgeons," telemedicine, and other modern advances have changed the "traditional" practice of medicine. We all realize that medicine, as it was practiced, will change to accommodate new advances and challenges. In one way we are responsible for some of the factors at work in the evolving health care industry. It would appear that soon, our practices may resemble the infirmary on Star Trek.

The insurance industry is another factor influencing the total health care picture. One spokesman has said, "The patient is not the doctor's customer; the insurance company is." Sixty-nine percent of physicians work for third-party payors, and almost all have agreements with one or more insurance plans. In some cases, these companies are physician-owned and managed (or supposedly so), others are not. The spiraling costs of medical care have finally hit home and America's response, at this point, has been "managed care."

Managed care is a process whereby patients are carefully programmed into a cost-containing environment utilizing a variety of tools such as primary care, early discharge from hospitals, reduced fee for service, and health maintenance organizations, to name just a few. HMOs, PPOs, IPAs, PMAs, and MSOs are only some of the alphabet-soup groups that have sprung up to provide medical services while, one hopes, reducing the cost of that care. Many physicians belong to more than one, and the number of these organizations will increase in the future. Capitation, shared liability, hospital purchase of individual and group practices, networking, outcomes-based standards, practice parameters and a host of others are in the mix of ideas being considered in the push to reduce health care costs.

HMOs, PPOs, IPAs, PMAs, and MSOs are only some of the alphabet-soup groups that have sprung up to provide medical services while, one hopes, reducing the cost of that care.

Circumstances are at work to force changes in the practice of medicine. Shared liability, where the physician is paid bonuses or incurs penalties based on the cost of services rendered, has the potential, based on monetary considerations, to rob the patient of quality care. This is a departure from the ideal that the physician is the patient's advocate in seeking the patient's best interest, regardless of the cost. Some

members of large physician groups are told to order more tests, perform more procedures, or to see more patients per day in an effort to keep profits up. Insurance companies and HMO administrators are, in many instances, making medical decisions that should be made only by the physician.

The New England Journal of Medicine recently reported that U.S. Healthcare, a large HMO, spends only 74 percent of its revenues on medical care, while maintaining a $1.2 billion cash reserve and paying its CEO $20 million in salary and $534 million in company stock. This is not an indictment of all managed care plans, but such information must make it seem to John Q. Public that all is not on the up-and-up in the health care industry.

Legislatures, both state and federal, are now in the business of setting health policy. The Kansas Legislature recently mandated a two-day hospital stay for normal deliveries. This is another example of a non-medical body making health care policy and affecting the cost of medical care without any medical knowledge. It seems entirely possible that more and more legislated health policy, based on emotion and not sound data, will be mandated in the future.

The nursing groups are touting themselves as a cost-effective means of increasing access to care and as patient advocates through case management. They are willing to collaborate with physicians and see themselves as especially valuable in underserved areas.

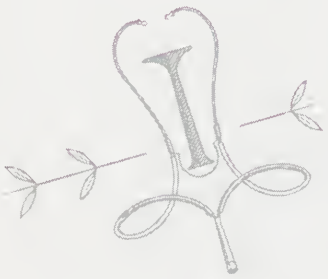
Has the public's opinion of doctors changed? Eavesdropping at non-medical gatherings (probably because all my friends are now seeing doctors more and more), it is apparent that patients still want to have "their" doctor—the one who cares about them and their condition. They are not fond of seeing a different physician at every visit or of not being able to reach "their" doctor in time of emergency. Their sense of having an old-fashioned doctor is fast fading, and they feel betrayed. It would be hard for them to support the medical profession when they feel that the profession has forgotten, or worse, abandoned them for its own purposes. Perhaps patients are expecting too much, especially of the doctor's time; perhaps bureaucracy, insurance forms, hospital rules and regulations, etc., have made the doctor's life more difficult and demanded more and more of his or her time. Perhaps patients are more prone to sue without cause now than in the "good old days." Perhaps . . . perhaps.

There are many different forces working today to lower health care costs. What will eventually work will depend on the public's willingness to accept the proposed changes. At this time, no one can predict what the outcome will be. One thing seems certain: everyone wants to play doctor and claims to have the right answer. The last attempt at universal health care was defeated because patients still want to have "their" doctor take care of them. Medicine is the only entity that can give the right answer, but will the public be willing to recognize and support our ideas when some of the derogatory things they hear about doctors and the profession ring true? W.E.M. KMS

It is apparent that patients still want to have "their" doctor–the one who cares about them and their condition.

Biodegradable implants in hand and wrist fracture management

Rafael J Fernandez, MD & George L Lucas, MD



Although it is well known that a fracture will usually heal despite the treatment method chosen, not all heal with acceptable functional results. The importance of limiting residual deformities and maintaining joint motion associated with fractures is paramount in hand injuries. Fracture management involves both art and science in order to realign the bony fragments, restore stability, and most importantly, care for the injured soft tissues.

Whether a fracture heals by primary or secondary healing depends on the method of treatment chosen. Secondary fracture healing occurs through formation of biologic splint or "callus." A callus originates from the hematoma at the fracture site, which ultimately calcifies and remodels according to Wolf's Law. Primary fracture healing occurs through bridging of the fracture by cutting cones in the absence of a callus. Cutting cones are composed of a collection of bone resorbing osteoblasts followed by osteoblasts, producing osteoid. Primary fracture healing occurs in the presence of rigid fixation.

The science of fracture management has evolved with aid of technologic advances. Hippocrates, the father of medicine, treated fractures with bandages, oils, and simple wooden splints. Traction devices and plaster of paris increased the armamentarium available to physicians for closed management of fractures. Operative intervention in fracture management was attempted before the twentieth century, but complications were common due to infection, poor implant design, and ignorance of biomechanical principles. The Arbeitsgemeinsheft fur Osteosynthese Fragen or The Association for the Study of Internal Fixation (ASIF), an international organization founded in Switzerland in 1958 by a group of physicians and engineers, works to reduce complications encountered in early operative fracture management. The principles laid down by this group have become the basis for modern fracture management and especially internal fixation.

The majority of hand fractures do not require operative management. Usually, closed manipulation with application of a splint or cast will lead to a successful outcome. Modern management of hand fractures, though, allows the physician numerous other treatment options.

Operative treatment of fractures provides an immediate internal splint applied directly to the surface of the bone, allowing earlier mobilization. Early mobilization decreases residual deformity, stiffness, and disuse osteopenia, which is especially important for maximum hand function.

Devices currently available for surgical management of fractures are manufactured from a variety of high grade metals and alloys, including surgical stainless steel, titanium, and cobalt. Miniaturization of previously bulky implants has expanded their use in the management of hand fractures. Advances in polymers have also allowed the development of implants which are radiolucent, and yet comparable in stability to metallic devices. Biodegradable implants are the next generation of devices designed for treatment of fractures, including those of the hand. Fixation devices available today vary in their rigidity, cost, degree of soft tissue disruption, and difficulty of application.

Metallic devices including wires, pins, plates, or screws, often require a second operation following fracture healing, in order to remove the device. Reasons for removal include: prevention of stress shielding, irritation of soft tissues, hardware breakage, and infection. The patient is exposed to additional risks associated with a second operation. The desire to eliminate such risk has spawned interest in the development of biodegradable implants.

In developing a biodegradable implant, many factors must be addressed. The material chosen and its breakdown products cannot be toxic, mutagenic, carcinogenic, or interfere with the biology of fracture healing. A biodegradable implant must not be rejected by the body's immune system. The implant must be sufficiently rigid to eliminate motion at the fracture, and of an elastic modulus similar to bone, in order to prevent stress shielding. Breakdown of the implant should be through a biological reaction, and the rate should be inversely proportional to the rate of bony healing. Finally, the cost of the implant must be reasonable.[1]

Biodegradable implants are made of copolymers such as lactide-glycolide and polyglycolide. These copolymers are broken down by hydrolysis.[1] Rods and pins made of these polymers have shown good results in fracture management. Drawbacks in the development of biodegradable plates include their thickness and the inability to contour the plate.[1] Biomechanical students have also shown such implants to be sensitive to torsional forces, which limit development of screws made of these materials.

Despite biomechanical difficulties, initial trials using biodegradable implants have shown good results with low complications when matched to the current standard, i.e. metallic implants. The German section of ASIF has developed a biodegradable implant that has shown good results. Their studies have demonstrated no infections, long durability, and expected degradation in the treatment of osteochondral fractures.[10] Hoffman et al treated forty distal radius fractures with biodegradable implants, again demonstrating good results at two years. Two cases of bacterial wound infection and nine patients that developed local inflammatory reactions, healed without further complications.[5] In treating extra-articular fractures of the hand, Kumta et al showed no statistical difference between the use of polglycolide implants or Kirschner wires.[7]

Application of biodegradable implants in ankle fractures has also demonstrated good results. Bostman compared biodegradable implants to ASIF metal plates and screws for displaced malleolar fractures. No difference was observed between the two groups in their ability to participate in sports at one year.[2] Bucholz compared the use of 4.0 millimeter polylactide screws vs. 4.0 metallic screws in the treatment of medial malleolar fractures. This study demonstrated no significant difference in operative or postoperative complications. His study did not find late spontaneous drainage in any patient.[4] Parks used biodegradable implants in podiatric surgery and found reactions only in patients over 40 years, and primarily in patients between 55-60 years of age.[8]

Fracture management is a dynamic field. Although biodegradable implants are in their infancy, early results are demonstrating favorable possibilities. Future research as is being done in the Orthopedic Research Laboratory of the University of Kansas School of Medicine–Wichita at St. Francis Regional Medical Center will hopefully develop new polymers and materials that are more bio-compatible. Such advances may reduce some of the difficulties described above, comparable to the evolution of operative treatment with metallic implants. KMS

Dr. George L Lucas is a professor and Chairman of the Section of Orthopedics, Department of Surgery, at the University of Kansas School of Medicine–Wichita. He is also the program director for the Orthopedic Residency Program. Dr. Rafael J Fernandez is a graduate of this program and is currently completing a sports medicine fellowship in Illinois.

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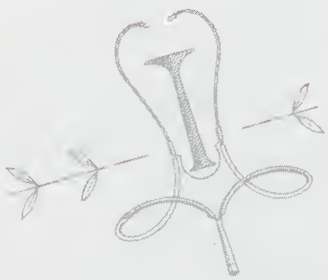
Vitamin D deficiency rickets in two breast-fed infants

FW Manfred Menking, MD



Recently, we encountered two breast-fed African-American children with florid vitamin D deficiency rickets. This report is intended to alert health care providers to proper prevention of this nutritional disorder.

Infant M.D. had been breast-fed to the age of 12 months. Due to a miscommunication, his pediatrician assumed feedings had been changed to commercial formula at four months and thus he received no vitamin supplements. Poor linear growth was noticed at an 11 month visit. At 14 months a fracture of the forearms was suspected because of swelling of both wrists. X-rays revealed advanced rickets with evidence of minor calcium deposition at the distal radial metaphyses. A complete skeletal survey confirmed the findings. (See Figure 1)

The mother reported that her son had received up to 16 ounces daily of 2 percent milk for the last two months. During the warmer season she had taken him out for walks in late afternoon and early evening hours. Following delivery she had not taken vitamins herself, but drank an estimated 20 ounces of milk daily.

Multiple serum chemistries were normal except for a low phosphorus of 2.5 mg/dl and elevated alkaline phosphatase of 1440 u/L (normal range 40-300). The calcium was 8.9 mg/dl. There was generalized aminoaciduria. Serum 1,25-dihydroxy vit. D (calcitriol) was reported as 70.5 pg/ml (normal range 18.0-62.0).

Infant T.C. was breast-fed without formula supplements. At seven months his head appeared disproportionately large (90th percentile), the anterior fontanelle measured 4x4 cm, and he had stopped growing. At eight months his length of 64 cm was 2.5 cm below the fifth percentile, his weight of 7.5 kg corresponded to the 10th percentile. A rachitic rosary was palpable. Serum chemistries showed a calcium of 7.9 mg/dl, phosphorus of 2.4 mg/dl, alkaline phosphatase of 1040 u/L but no other abnormalities. He was referred for treatment of rickets which was clearly apparent on X-rays. His mother had not taken vitamins post-delivery and consumed less than 2 cups of milk per day. She admitted that she had administered vitamins (400 units of vit. D/ml) prescribed for her infant at four weeks of age, irregularly, perhaps three times per week. Serum 25-hydroxy vit. D (calcidiol)

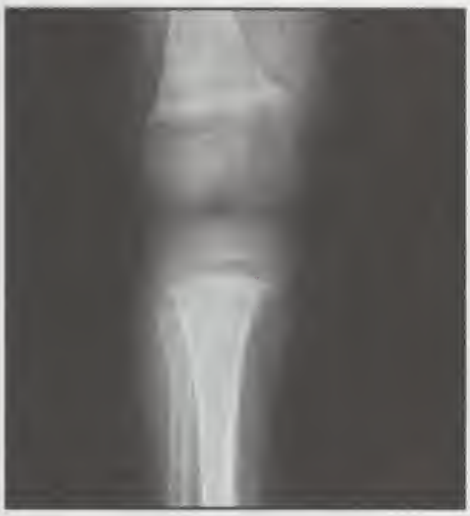


Figure 1. Patient M.D. Marked flaring and poor calcium deposition in metaphyses, particularly striking in the distal tibia. Note the great distance between metaphyses and epiphyses of the knee compared to Figure 2.

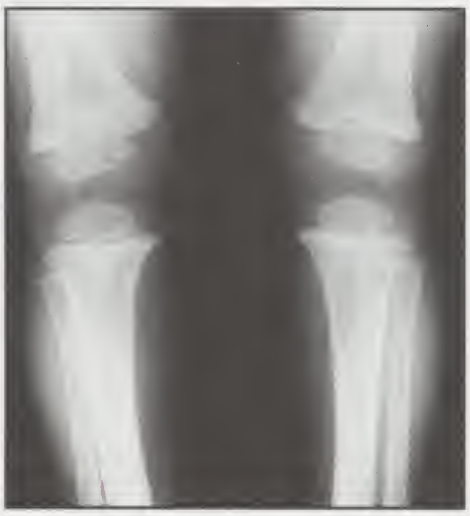


Figure 2. Patient M.D. Complete healing of rickets, but persistent bowing of the lower tibias one year after treatment.

was low with 9 ng/ml, calcitriol was 130 pg/ml, above the normal range.

Both infants were admitted for 24 hours and received a total of 600,000 units of Ergocalciferol (vit. D2) in six doses at intervals of two hours and calcium lactate by mouth. Serum calcium rose to the normal range within 24 hours, the serum phosphorus completely normalized within one month, while the alkaline phosphatase declined to normal more gradually. Marked calcium deposition in the metaphyses was apparent on follow-up X-rays one month after treatment with complete healing of rickets but persistent bowing of the lower tibia (patient M.D.) one year later. (See Figure 2)

There have been repeated debates about the need for vitamin D supplements for breast-fed infants. Greer and Marshall[1] found no evidence of vitamin D deficiency in almost exclusively caucasean, six-month old breast-fed infants in Madison, WI, raised without vitamin D supplements. Nevertheless, multiple reports of deficiency rickets in totally breast-fed infants have been published in this and other countries. Manifestations usually present towards the end of the first year of life. A common feature of all case reports is the lack of adequate exposure to sunshine. Human milk has low levels of vitamin D[2]. Finnish investigators[3] determined that lactating mothers need a daily intake of 2000 units of vitamin D to achieve concentrations in their 15-week old infants approaching those with direct administration of 400 units to their babies. Harrison and Harrison[2] summarized the extensive research findings accumulated during this century stating that the natural source of vitamin D for infants is derived from ultraviolet light-induced conversion of 7-dehydro-cholesterol rather than from breast milk.

We treated our rachitic infants with fractions of 100,000 units of vitamin D for a total of 600,000 units administered over 12 hours. This so-called "stoss" therapy (from German: to push) commonly used in Europe and elsewhere and advocated by Harrison and Harrison[2] as well as recently by Shah and Finberg[4] helps to differentiate deficiency from vitamin D resistant forms of rickets. It will result in prompt improvement of the abnormally low serum phosphorus (a consequence of compensatory hyperparathyroidism) and rapid X-ray evidence of metaphyseal calcium deposition. Hypocalcemia seen in deficiency rickets reflects refractoriness of bone to parathormone in the absence of vitamin D.

When combined with generous oral calcium administration, stoss therapy will prevent rachitic tetany commonly seen in the early phase of treatment with small doses of vitamin D. Indeed, the calcium levels of our patients had risen to 9.5 (Patient M.D.) And 10.5 mg/dl (Patient T.C.) in less than 18 hours, without subsequent hypercalcemia. Stoss therapy ensures adequate calcidiol levels for about three months[5].

The serum concentration of 25-hydroxy-D was below the normal range in infant T.C. It is a sensitive index of vitamin D nutritional status. The laboratory failed to supply this metabolite for infant M.D. 1,25-dihydroxy-D was elevated in both infants due to secondary hyperparathyroidism as described in other case reports.

Breast feeding mothers should be reminded to properly protect their infants against this deficiency.

With mothers quickly rejoining the work force prolonged breast-feeding is not very common in our society. In the United States all infant formulas and milk are fortified with vitamin D. Thus, overt rickets is rarely diagnosed and there may be little familiarity with its manifestations. In patient M.D., rickets was

VITAMIN D DEFICIENCY RICKETS IN TWO BREAST-FED INFANTS

Continued from page 11

a chance finding since he was treated because of a burn and accidentally found to have swollen wrists. Thus, the disorder may remain unrecognized in some infants and toddlers.

Formerly rickets was most prevalent during winter months. Under present living conditions, dark skinned children in particular may not receive sufficient sun exposure even in the warmer seasons. Breast feeding mothers should be reminded to properly protect their infants against this deficiency. KMS

Dr. FW Manfred Menking practices pediatrics and pediatric endocrinology at the Wichita Clinic. He would like to thank Drs. Leonard Sullivan and Susan Menking for the referral of their respective patients.

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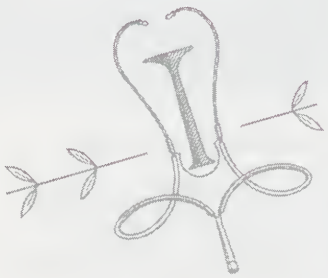
Lipid screening and treatment by cardiologists have not improved

David G Meyers, MD & Brad T Steinle, MSEd, MD



ABSTRACT

MUCH EFFORT BY THE NATIONAL CHOLESTEROL EDUCATION PROGRAM (NCEP) AND others has been made to induce physicians to screen for and treat lipid abnormalities in patients with coronary heart disease. We measured the effect of these efforts in a single group of cardiovascular specialists. We reviewed 20 percent of applicable patient records from 1987, 1989, and 1994 was performed to identify documented screening (cholesterol levels or lipid profiles) and treatment over 12 months after an index admission for coronary heart disease, along with a survey of physician acquaintance with NCEP guidelines, among the eight cardiovascular physicians. In the 160 patients with angina pectoris or myocardial infarction, total cholesterol levels were determined in 77-95 percent and lipid profiles determined in 2-11 percent. Treatment for cholesterol. greater than 150 mg/dl was initiated in 14-32 percent. These rates did not significantly improve over the study period. Yet, all the physicians were acquainted with the NCEP and five of the eight perceived their screening and treatment to be more aggressive in 1994 than 1987. Lipid screening and treatment by cardiovascular specialists have not improved despite copious supportive literature. Barriers other than lack of knowledge may impede implementation of this effective therapy.

While primary care physicians and the general public have recently begun to recognize the importance of lipid screening and treatment[1], cardiologists have been more resistant to lipid management. A chart review performed in Ontario from 1983 to 1985 found that only 18 percent of patients admitted for coronary artery disease had lipid profiles ordered and 11 percent received diet prescriptions[2]. In New York City between 1988 and 1989, Cohen and associates[3] performed lipid profiles on patients admitted for coronary angiography and found that only 17 percent of those patients with elevated serum cholesterol were subsequently further evaluated or treated for lipid abnormalities by their attending cardiologists. Through dissemination of educational materials and guidelines, at a cost of $1.5 million per year, the NCEP has attempted to improve public and physician awareness of the importance of lipid screening and treatment. In

1988, published guidelines, the Adult Treatment Panel (ATP-I)[4], emphasizing primary prevention were mailed to 150,000 physicians. In 1993, updated guidelines emphasizing secondary prevention were published (ATP-II)[5].

Subjects and Methods

We performed a chart audit for the years 1987, 1989 and 1994 to determine the impact of the NCEP (and other publications) on cardiovascular specialists' screening and treatment rates. A stable seven man, one woman, urban hospital-based group of board-certified cardiovascular physicians (age=46±11 years) {part of a large multi-specialty group} allowed a single abstractor to review every fifth chart by chronological order of discharge from 1987, 1989 and January-July 1994 with a principle diagnosis of angina pectoris (ICD-9 code 413.9) or myocardial infarction (ICD-9 code 410.11-410.91). No attempt was made to confirm the diagnoses. The index admission and all records for both inpatients and outpatient visits plus laboratory results from the multi-specialty practice which utilized a unified medical records systems for the subsequent 12 months, were reviewed for evidence of screening and treatment. Screening was defined as a laboratory report of plasma cholesterol determination or as a lipid profile (measured total cholesterol, high density lipoprotein cholesterol and triglycerides with calculated low density lipoprotein.) Treatment was defined as documentation in notes or orders of a low-fat diet prescription, referral to a dietitian or prescription of a lipid modifying drug. Most patients subsequently were seen at least once as outpatients by the cardiovascular group (92 percent) and nearly all the rest were followed within the larger multi-specialty group (four percent). Only six patients received no recorded follow-up. The number of deaths subsequent to the index admission was not determined.

The eight physicians were given a written questionnaire eliciting their acquaintance with NCEP guidelines, thresholds and goals for treatment, [4-5] and self-perceived changes in attitudes toward lipid-screening and therapy from 1987 to 1994. Data analysis used ANOVA and Fisher's exact test with the alpha significance level set at <0.05, 2-tailed.

Table 1: Patient Characteristics

	1987	1989	1994	p-value
n	56	60	44	
Age (yrs)	50±11	58±14	63±14	NS
Male	37	44	32	NS
Female	19	16	12	
White	47	51	37	NS
Black	7	7	6	
Hispanic	2	2	1	
Stable angina	30	35	21	NS
Unstable angina	6	2	3	
Q-wave MI	15	18	13	
non Q-wave MI	5	5	7	
Total cholesterol	204±44	218±46	206±43	NS

Note: age and total cholesterol given as mean±standard deviation

Results

No significant differences in patient characteristics or distribution of diagnoses were noted among the years surveyed (Table 1). Plasma total cholesterol, as part of a chemistry profile, was frequently obtained, but lipid profiles were rarely ordered (Table 2). No lipid profiles were obtained at subsequent visits in patients not having a profile at the index visit. Frequencies of obtaining either test did not change across the surveyed years. Among patients in whom total cholesterol was determined, 50 percent had levels above the ATP-I[4] treatment goal of 200 mg percent and more than 90 percent had levels above the ATP-II[5] treatment goal of 150 mg percent (Table 3). Table 3 also demonstrates a doubling in lipid modifying treatment between 1987 and 1994. Yet, about two-thirds of patients were not treated with diet or drugs as recommended by the NCEP guidelines appropriate to the year that the patient was screened. This pattern of performance did not significantly improve across the surveyed years. Results of the lipid profiles obtained evoked no treatment from the attending physicians.

The questionnaire suggested that all eight physicians were acquainted with NCEP ATP-I[4] and six knew the APT-II[5] guidelines. Five perceived themselves as currently more aggressive regarding lipids, two were unchanged, and one was less aggressive than in 1987. In 1994, the mean level of total cholesterol for which these physicians believed at least dietary treatment to be required was 195 mg percent (range=180-240

LIPID SCREENING

Continued from page 15

mg percent) and the goal of treatment in their patients with coronary artery disease was 175 percent (range=150-200 mg percent).

COMMENT

Our data shows that cardiovascular specialists continue not to consistently screen and treat lipids, even after numerous supportive published reports and the efforts of the NCEP. Indeed, the current results are remarkably similar to results obtained before the NCEP reports.[2] Recently, screening rates of 53-56 percent have been reported by similar surveys.[6,7] While some improvement was observed, it is apparent that rates of screening and treatment are less than the rates implicit in the NCEP guidelines. Because lipoprotein fractions were seldom obtained in the current study, it was necessary to phrase all cut point questions in terms of total cholesterol instead of low density lipoprotein.

It is possible that the limited statistical power of our sample (approximate n=50 in each year sampled) failed to detect improved screening and treatment. The rates are based solely on performance documented in the medical records. While virtually all patients obtained follow-up within the large multi-specialty practice, some may have obtained screening and treatment elsewhere, or which was not documented in available records. The small number of cardiovascular physicians studied and the fact that they were in a single practice group may limit the implications of our findings.

TABLE 2: FREQUENCY OF LIPID SCREENINGS

	1987	1989	1994	P-value
n	56	60	44	
Total cholesterol	46 (87%)	57 (95%)	34 (77%)	NS
Lipid profile	1 (2%)	5 (8%)	5 (11%)	NS

Failure of the NCEP to make cardiovascular physicians aware of its recommendations is not the problem. Physicians appear to be acquainted with the NCEP,[4,5] although some have not acquired a working knowledge of the specific guidelines or do not fully agree with their validity.[7] Lipid screening and treatment among primary-care physicians have recently improved.[1] Why then have cardiovascular specialists in particular not broadened and intensified their lipid management? While some have argued that physician education and consensus-based guidelines are ineffective in modifying physician practice behaviors,[9] it is not apparent why guidelines would be followed by primary-care physicians, but not by cardiovascular specialists. Several barriers to compliance–some unique to subspecialists–have been suggested.[10,11] These include lack of time, lack of interest in risk factors, inadequate reimbursement, limited access to treatment resources, limited skills with diet and drug prescription, lack of confidence in diet counseling, limited self-efficacy, and a belief that risk factor modification is the responsibility of primary-care physicians.[3,10,11]

Because lipid screening and treatment have not improved in spite of general dissemination of information, targeted education and physician-independent practices such as computer-assisted screening, critical pathways, and case managers might become desirable. KMS

Presented at the American College of Preventive Medicine, Prevention '95, New Orleans, LA, March 31, 1995. *Dr. Meyers is an Associate Professor of Internal Medicine and Preventive Medicine at the University of Kansas Medical Center. Dr. Steinle is a resident physician at the University of Kansas Medical Center. Correspondence and reprint requests: David G Meyers, MD, Division of Cardiovascular Diseases, University of Kansas Medical Center, 3901 Rainbow Blvd, Kansas City, KS, 66160-7378.*

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TABLE 3: PREVALENCE OF LIPID ABNORMALITIES AND FREQUENCY OF LIPID TREATMENT

Threshold	1987	1989	1994	P-value
Patients with total cholesterol > 200 mg/dl				
n	25	37	19	NS
(% prevelance)	(54%)	(65%)	(56%)	
Diet treated	825	15	29	NS
(%)	(32%)	(68%)	(78%)	
Drug treated	0	2	8	NS
(%)	(0%)	(5%)	(43%)	
Patients with total cholesterol > 150mg/dl				
n	42	54	31	NS
(% prevelance)	(91%)	(95%)	(91%)	
Diet treated	14	32	21	NS
(%)	(33%)	(59%)	(67%)	
Drug treated	0	2	4	NS
(%)	(0%)	(4%)	(13%)	
Patients with LDL >130 mg./dl				
n	1	4	3	NS
(% prevelance)	(100%)	(80%)	(60%)	
Drug treated	0	0	0	NS
(%)	(0%)	(0%)	(0%)	
Patients with LDL >100 mg/dl				
n	1	4	4	NS
(% prevelance)	(100%)	(20%)	(80%)	
Drug treated	0	0	0	
(%)	(0%)	(0%)	(0%)	
Patients with HDL < 35 mg/dl				
n	1	1	4	NS
(% prevelance)	(100%)	(20%)	(80%)	
Drug treated	0	0	0	NS
(%)	(0%)	(0%)	(0%)	

Note: HDL=high density lipoprotein; LDL= low density lipoprotein

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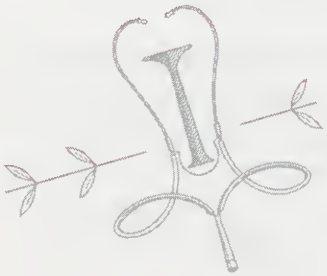
Heredity and systemic lupus erythematosus: dissecting a complex genetic disease

Timothy S Shaver, MD; John B Harley, MD; & Kathy L Moser, PhD



INTRODUCTION

THE SEARCH FOR CAUSES OF SYSTEMIC autoimmune diseases has proven to be challenging and often frustrating for clinicians and scientists over the past several decades. Few of these disorders have garnered as much attention as systemic lupus erythematosus (SLE). This condition has likely generated substantial interest not only because SLE is common, with a prevalence of one in 2,000 from European-derived populations[1], but also because peak incidence rates are often reported in women during child-bearing years[2], thus profoundly affecting quality, and often duration, of life.

While the pathogenesis of SLE has remained elusive, there is substantial evidence that genetic factors play a significant role. The prevalence of SLE in first and second degree relatives of SLE patients has been reported as 7-12 percent[3-5], an approximate 200-fold increase relative to European-American populations. Twin studies much more convincingly suggest a genetic etiology. Whereas 2-5 percent of dizygotic twins and nontwin siblings are concordant for SLE, disease concordance rates in monozygotic twins have ranged from 14-69 percent[6-8].

Despite the evidence cited above, a precise genetic mechanism leading to development of SLE remains to be elucidated. This article will review existing evidence for genetic transmission for autoimmunity, in general, and SLE in particular. We will also discuss candidate genes for SLE, as well as exploring principles and difficulties inherent in genetic linkage pertinent to the study of complex hereditary diseases such as SLE.

PRINCIPLES OF GENETIC RESEARCH

Before we can begin a meaningful discussion of potential genetic mechanisms underlying the pathogenesis of SLE, we must first review the principles fundamental to the study of heritable diseases. Conditions such as Huntington's chorea, cystic fibrosis, polycystic kidney disease, and neurofibromatosis, which appear to follow a simply Mendelian mode of inheritance lend themselves most easily to genetic investigation. The mode of transmission of these diseases is readily inferred by direct observation of the pattern of

affected members within families and by application of simple statistical tests. Beginning with these observations, researchers have applied sophisticated modern methods of analysis, subsequently leading to localization of the genetic mutation responsible for cystic fibrosis to chromosome 79. This information will have a major impact on screening presymptomatic patients and developing new therapies. Similar advances in other genetic diseases are forthcoming and anticipated.

Unfortunately, additional variables appear to be operative in many heritable illnesses, confounding such analysis. First of all, certain diseases may be polygenic, requiring two or more genes in order to be expressed. Secondly, expression of a given genotype may be influenced, positively or negatively, by environmental or random (stochastic) factors. The influence of this variation is known as penetrance, and is expressed as the probability that the phenotype (or disease) will manifest, given a certain genotype. Finally, certain illnesses may result from multiple potential disease-related loci not consistently shared among all families, a phenomenon known as genetic heterogeneity.

The effect of such confounding factors are found in a variety of complex genetic disorders. Colon cancer, for example, is associated with a mutation of the ras oncogene as well as deletions in chromosomes 5, 17, and 18.[10-12] The degree of interaction between such genetic alterations is unclear at present, but there are likely several ways susceptibility to colon cancer may be inherited (genetic heterogeneity). Interactions may be present between multiple alleles (a phenomenon known as epistasis or a gene dosage effect), in addition to environmental contributions (penetrance).

While associations between various diseases and certain genetic markers can be found when sampling sufficiently large populations, these findings only indirectly suggest that these markers actually confer disease susceptibility. Identification of inherited disease-related loci must be determined by linkage analysis. Linkage analysis differs from population studies in that families must be studied. Within such families, the tendency for a specific allele at a particular genetic "marker" locus to cosegregate with the disease in a family determines the extent to which this locus is linked to a potential disease locus in the chromosomal region of interest. Once linkage is established to a chromosomal region, further studies can focus on identification of the exact gene and characterization of relevant mutations.

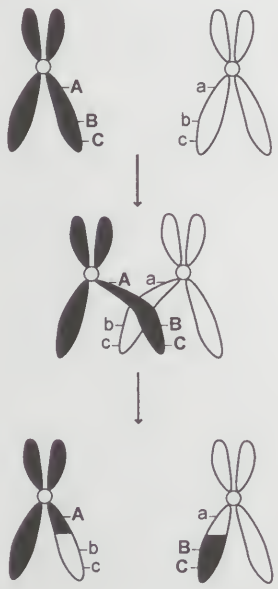


Figure 1. Crossover is depicted between two homologous chromosomes. Because of their proximity, loci B(b) and C(c) are more closely linked than A(a) and B(b) and are therefore more likely to be inherited together.

When performing linkage analysis, the relative distances between a disease locus and a marker locus can be estimated by utilizing the principle of genetic recombination, or crossover. This process is depicted in Figure 1. During meiosis, homologous chromosomes from the parents participate in an equal exchange of genetic material. The result of this exchange is reflected in the chromosomal composition of the offspring. The closer a genetic marker locus resides to the putative disease-related gene, the higher the likelihood they will be inherited together. The magnitude of this effect may be calculated as an odds ratio for the probability that the two loci are linked versus the probability that the loci segregate independently. The log of this odds ratio is known as the lod score, and when calculated at a given range of recombination fractions, an estimate of the genetic distance between the two loci can be made. At a maximum lod score, the probability is highest that the genetic marker resides at or very near the actual disease-related gene. A lod score of at least 3.0, or in some circumstances at least 5.0, is usually required to establish linkage. At these levels the possibility that the observed data occurred by chance is very small, approximately 1:1,000 and 1:100,000, respectively. Genetic markers utilized in linkage studies involve protein polymorphisms, restriction fragment length polymorphisms (RFLP) or polymerase chain reaction (PCR) analysis of short

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tandem repeats (STR's). A full discussion of these procedures is beyond the scope of this article.

HOW IS SLE INHERITED?

The inheritance of SLE appears to be complex and not likely to be explained by a single-locus homogeneous simple Mendelian model, though individual examples of apparent autosomal dominant, autosomal recessive, and sex-linked transmission have been observed in isolated pedigrees.[4] It has been calculated, based on differences in disease concordance rates between monozygotic and dizygotic twins, that four or more genes may be involved in conferring disease susceptibility.[13] Whether these estimates may be attributable to genetic heterogenetiy, epistasis, stochastic factors, or a combination of these variables is unclear.

Perhaps serologic abnormalities and autoimmune diseases in general are more directly heritable than SLE itself. Autoantibody profiles in monozygotic twins are remarkably similar, even when one twin is unaffected or fails to meet criteria for SLE.[14] Various immunogic abnormalities such as hypergammaglobulinemia, rheumatoid factor, biologic false positive tests for syphilis, antinuclear antibodies, anti-RNA antibodies, and lymphocytotoxic antibodies have all been observed in increased frequency in family members of SLE patients when compared to control populations.[15-17] Moreover, autoimmune diseases other than SLE, including rheumatoid arthritis, Sjogren's syndrome, immune thrombocytopenia and autoimmune thyroiditis have been found in 13 percent of relatives of SLE patients.[3]

Such observations have led Bias and colleagues to postulate the existence of an "autoimmune phenotype."[18-20] The presence of any one of the following characteristics, which tend to segregate most closely within families with autoimmunity, define this phenotype:

1) presumed autoimmune disease,
2) positive antinuclear antibody (ANA),
3) positive anti-single stranded DNA,
4) biologic false positive for syphilis, and,
5) positive rheumatoid factor.

In the original pedigrees studies, this putative trait seemed to demonstrate autosomal dominant inheritance with an estimated penetrance of 92 percent in females and 49 percent in males. They proposed that other modifying genes such as those in the major histocompatibility complex (MHC or HLA) may confer specificity to the expression of autoimmunity in a given individual.[18]

We recently attempted to validate this model on a large extended pedigree containing eight members meeting criteria for SLE.[21] Computer simulation studies disclosed a maximum lod score under a fully penetrant autosomal recessive model, contrasting with Bias' findings. This simulated maximum lod score for the autoimmune phenotype was, however, over two units (100-fold) higher than that obtained for SLE, which supports the notion that this proposed trait is more directly accessible to genetic analysis.[18,20]

WHAT GENES ARE INVOLVED?

Despite the level of complexity inherent in defining genetic mechanisms involved in SLE, population-based studies and case reports provide several candidate genes which may direct formal genetic linkage studies. The most extensively studied loci among these reside within the MHC or HLA region on the short arm of chromosome 6. Certain Class II MHC antigens have been shown in increased frequency in patients with SLE, and particularly in association with specific serologic profiles.[22,23] Among caucasians, HLA- DR3, by itself or in association with HLA-B8,[22] is associated with an increased risk of developing SLE, particularly with older age at onset.[24] These MHC associations may be more tightly correlated with specific autoantibodies. Anti-Ro/SSA antibodies are strongly associated with HLA-DQ1/DQ2 heterozygotes,[25] particularly in relationship to T cell receptor beta polymorphisms.[26] Antibodies to La/SSB, on the other hand, are most closely associated with the HLA-B8, DR3 haplotype, while anti-nRNP antibodies are associated with HLA-DR4.[23]

The presence of complement deficiency states has also been shown in increased frequency in SLE patients. Null alleles of C4A, residing within the MHC region, appear to be important genetic markers for SLE in both blacks and caucasians. While these alleles may be seen as part of an extended HLA-B8, DR3 haplotype, the association holds regardless of the presence of other HLA haplotypes, suggesting that C4A null alleles may be the primary factor in conferring increased susceptibility to

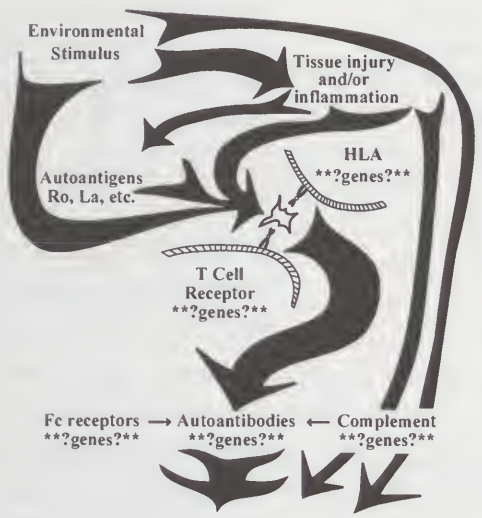

Figure 2. Model for lupus pathogenesis. The environmental stimulus leads to tissue infection or injury. Eventually lupus autoantigens become involved in an immune response that is dependent upon histocompatibility alleles and T-cell receptors. Both of these cell-surface molecules are highly polymorphic. The autoantibodies generated and their consequences can be modulated by Fc receptors and complement components. Each of the molecules with a suspected pathogenic or etiologic role is indicated by **?genes?**. Used by permission from Harley, et. al. 1994[33].

SLE. [22,27,28] While less well described, SLE and lupus-like disease has also been shown to occur with increased frequency in the setting of C2 deficiency.[29] This may especially hold true when anti-Ro/SSA antibodies are present.[30]

Genetic loci residing outside the MHC region aren't well studied, but may prove to be valuable candidate genes for SLE. Deletions in the gene encoding the Fcgamma R III receptor on neutrophils, which is involved in the clearance of circulating immune complexes, have been described in SLE patients.[31,32] Moreover, there has been a trend toward genetic linkage of the Fcgamma R III receptor with SLE observed in multiplex black families in preliminary studies[33]. Finally, several immunoglobulin gene Gm allotypes (markers of IgG heavy chains) are associated with SLE in black patients,[34] and abnormal interleukin-2 activitity have been observed in family members of SLE patients, potentially attributable to either genetic abnormalities or environmental effects.[35] While all of the above associations are compelling and suggest a participatory role for particular loci in the genetics of SLE as well as focusing future investigation by more sophisticated methods, the only definitive way to prove an etiologic role of these genes is through formal genetic linkage studies.

OTHER FACTORS IN THE DEVELOPMENT OF SLE

Despite considerable evidence for a genetic etiology, environmental factors also appear to play a significant role in the pathogenesis of SLE. First of all, while disease concordance rates in monozygotic twins are high, they are far short of 100 percent, consistent with existence of a significant environmental contribution.[6-8] Moreover, disease onset in siblings occurs more closely together in time than in chronologic age [36], possibly implicating a common environmental exposure. Furthermore, pet dogs of SLE patients[37] as well as laboratory workers handling SLE sera[38] have been noted to possess various autoantibodies.

Perhaps more convincing evidence can be found by examing serologic data from nonconsanguineous relatives in SLE pedigrees. Cleland, for example, found ANA positivity in 52.9 percent of consanguineous relatives of SLE patients as well as 56.5 percent of nonconsanguineous relatives who were household contacts.[39] In an SLE pedigree we collected, all members were evaluated for the presence of the autoimmune trait (previously described by Bias and colleagues). Surprisingly, 50 percent of nonconsanguineous relatives met criteria for the autoimmune phenotype, compared with 12.5 percent of matched laboratory controls ($p<0.05$). We also pooled 19 nonconsanguineous relatives from 15 additional pedigrees and found that a similar percentage (47.3 percent) had features of the autoimmune phenotype, suggesting that this feature may be common to many families multiplex for SLE.[21]

What environmental factors may be involved? Epidemiologic, laboratory and clinical data reveal several possibilities. Infectious agents such as parvovirus,[40] type C retroviruses,[41] and vesicular stomatitis virus[42] have been implicated as well as aniline hair dyes[43] and L-canavinine, a nonprotein amino acid found in alfalfa sprouts causing SLE-like disease in non-human primates[44]. Direct evidence for any of these agents in the pathogenesis of SLE is, however, far from conclusive.

The additional influence of gender and hormonal status adds another level of complexity to the study of SLE. The importance of these factors is seen most clearly in the 9:1 female to male ratio of disease prevalence.[45] This is further underscored by the observation that female predominance for SLE is less pronounced prior to menarche and after

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menopause, peaking during active childbearing years.[46] The diminished penetrance of the autoimmune phenotype in males (49 percent) compared to that observed in females (92 percent) adds additional support to an influence of gonadal hormones.[18] Direct evidence of hormonal effects can be seen in murine models for SLE, in which estrogens appear to accelerate the course of experimentally induced nephritis, while androgens attenuate disease severity.[47-48] Moreover, Lahita has described abnormalities in both estrogen[49] and testosterone[50] metabolism in female SLE patients. It appears, then, that gonadal hormones play a modulatory role in the development or maintainance of autoimmunity and/or SLE, but are not likely to play a direct role in pathogenesis.

SUMMARY

The etiology of SLE appears to be exceedingly complex and possibly heterogeneous, with genetics and environment both making substantial contributions. A schematic representation of potential mechanisms is depicted in Figure 2. We may not fully understand the pathogenesis of this disease until we unravel the relative contributions of each component to the development of SLE. While genetic mechanisms involved in SLE remain obscure, we now have available elegant laboratory techniques for analysis of genetic loci as well as computer technology which permits simulation and analysis of the transmission of complex genetic traits among multiple families and demographic groups. What remains is the painstaking task of collecting families multiplex for SLE and analyzing multiple sets of clinical, serologic, and genetic data within and between these pedigrees. Such studies are currently underway and will hopefully increase understanding of this enigmatic and complex autoimmune disorder. KMS

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Doctor Fabrique

D Cramer Reed, MD

I AM AWARE THAT THERE ARE THOSE AMONG you who insist that Dr. Fabrique and I were contemporaneous. I am here to refute that rumor. Actually, I'm five years older.

Andrew Hinsdale Fabrique was born in Harrison County, Indiana, September 9, 1842, the ninth of 10 children, eight of whom survived to adulthood.

His parents, both born in Vermont, were descendants of the old French Huguenots. His father died when Andrew was seven, leaving his mother to raise 10 children alone.

At 16, after spending some time in Centre College, he taught school, often staying just a few pages ahead of his students. When arithmetic problems were too tough, he'd walk 10 miles to the home of a minister for help with the solutions.

Because of his French name, he was offered an opportunity in New Orleans with a Dr. Piquet, who also operated a drugstore. It was he who added much to young Andrew's social and cultural development by insisting that he read good literature and attend the opera on his free nights. Here, too, he was able to attend medical lectures at Tulane.

When the Civil War broke out, he joined Company A, 12th Indiana Infantry. Acquaintances described him as being in prime physical condition, "of fair complexion, brown hair, large nose and ears, sparkling blue eyes, nineteen years old, weighing 160 pounds, and 6 feet 4 inches tall...he had all the requirements of a good soldier," which he proved to be. In 1862, at Shiloh, his left arm was shattered at the elbow. Amputation was strongly advised and just as strongly rejected. He was able to regain good use of his fingers and hand and returned to active duty three months later.

The following year he was wounded a second time, and in July, 1865, was mustered out of the service with the rank of major.

It is interesting to know that he did not accept a pension until he was past 70 and retired from practice. He felt that by that time the other soldiers had been paid their share, making his pension justifiable.

After the war Andrew moved to Aurora, Illinois, and married Sarah Philler. They had one child, Mattie Lee. During his three years there, and while successfully operating a drug store, he attended lectures at Rush Medical College, made calls and filled prescriptions for an older physician.

In 1869, following a fire which destroyed the drugstore, the Fabrique family moved to Topeka. Shortly thereafter, Dr. Fabrique set out in a covered wagon to explore El Dorado, Augusta, Wichita, and Arkansas City to determine where he wanted to hang out his shingle. He settled on Wichita ". . . because from a rise called Fairmount, I could see this wonderful valley of the Arkansas River stretching away to the Northwest as far as the eye could see." He never wavered from his enthusiasm for the area.

When Andrew Hinsdale Fabrique arrived in 1869, Wichita was just a tiny village. This contemporary of Wyatt Earp lived to see it become the state's largest city. In the early 1870s, his practice, like that of his compatriots, carried him east to the Walnut River, North to Newton, South to Indian territory, and "west as far as one could ride in two days." By the end of the 70s, the pioneer period of Kansas medicine was passing, and the country doctor began to give way to the town doctor. Crumbine called him a link between the old and the new.

When Andrew Hinsdale Fabrique arrived in 1869, Wichita was just a tiny village. This contemporary of Wyatt Earp lived to see it become the state's largest city.

Upon his arrival here, he selected a parcel of land at the NW corner of Central and Lawrence (now Broadway) and began construction of an 18' by 30' two-room house for his family. Now and then he would add on another room—no architectural plan—just wherever the carpenter thought it would be easiest. Some of his friends claimed he built on when he had a good fracture case or had been lucky at poker. He did not deny the rumor.

The fees which Fabrique and his contemporaries charged were modest and geared to the patient's ability to pay. Hard cash was in short supply. He never accepted payment from pensioners, working girls or poor widows or orphans. He believed that it was impossible for a man to be a good physician and a financier at the same time.

Victor Murdock, famous editor and friend, wrote that in his office the old doctor stored his bills receivable. Once in a

DR. FABRIQUE

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while he would fan them across his thumb like a deck of cards. Some might be presented for payment, but many were never sent.

The average charge for a house call during the day was about $1.50; though some doctors charged $2. Obstetrician cases and tonsillectomies were $15.00.

Much of Dr. Fabrique's medical work in the early days was in obstetrics. In 1887, he and Dr. James Oldham formed a partnership to establish a hospital. They rented a house on North 4th Street with $50 of borrowed money.

Even working exceedingly long hours, the venture wasn't financially successful. The hospital was closed in 1889. Later in the same year Bishop Hennesy contacted Sisters of the Sorrowful Mother who reopened the hospital, naming it St. Francis. Dr. Fabrique thus entered into a long association with the enterprise and started the first intern program in obstetrics, which he personally supervised until his retirement in 1911. The term "Fab's Boys" originated with his dedication to the graduate medical education program. It was several of these devoted, young physicians who in 1905 contacted Northwestern University and arranged to have a regular medical degree conferred on him at age 63.

Several unsuccessful attempts to found medical schools had taken place in Kansas. One final interesting, though abortive attempt, began in Wichita in 1889. Andy Fabrique and 17 of his colleagues bought shares of the Wichita Medical College which succeeded in opening its doors for 2 four-month terms. Here, too, the would-be educators were plagued by the shortage of anatomical material and clinical facilities; in addition the benches of students were not overflowing.

In spite of a very active practice, Dr. Fabrique was very civic minded. Howard Clark described him as, ". . .a pillar and builder of Wichita from the time it was a village until it became a full-grown city." He served on the first city council (known as the pioneer civilization administration); was instrumental in bringing the Santa Fe Railroad from Newton; getting the "cattle trade" for Wichita; on the committee for the first public library; president of the local school board; plus a number of other community activities. He convinced William Greiffenstein to serve as mayor and the two men formed a local syndicate which issued bonds to build Turner Hall at First and Market where the literary society met, school plays were performed, as well as with vaudeville and opera. He and Dr. Charles Furley organized the South Kansas Medical Society which functioned until 1903 when the MSSC was formed.

At the same time, he was friendly with most of the other city physicians. It is written that Fab was especially fond of Drs. Bowers, Martin Hagan, JD Clark, DI Maggard, and Fred Lyons.

In his "History of the Sedgwick County Medical Society," Dr. Clark wrote, "It is high time that everyone becomes better acquainted with the man who has been mentioned so freely as 'Fab'. There is no doubt that he blazed the trail for modern medicine in Wichita—in fact, the state of Kansas—and did more than any man of his time to bring good medicine to his state."

Dr. Fabrique performed his last surgery at age 74 without the aid of glasses. He died when he was in his 86th year, greatly admired in the community and generally recognized as a "doctor's doctor." KMS

Dr. D Cramer Reed is the Vice President of Senior Initiatives at the Wesley Medical Center in Wichita.

Life after Medical School

Warren E Meyer, MD

Leonard Laster, MD; W W Norton & Company; hard cover, 344 pages, $27.50

This book consists of interviews with 32 doctors who describe the factors that brought them into medicine, influenced their choice of specialty, lead some of them to career changes in addition to or after practice, and some of their ideas about the future of medicine and the reform of the health care system.

The book is divided into five parts entitled "The Basic Cut," "Generalist or Specialist," "Which Person for Which Path," "National Health Policy," and "Confronting Obstacles and Setbacks."

"Basic Cuts" deals with medicine, surgery, psychiatry, anesthesiology, pathology, radiology and curiously, the corporate CEO and the foundation president.

The "Generalist or Specialist" section deals with a variety of specialty fields from general medicine to clinical research and fairly represents those areas of clinical practice detailing the doctor's choice of each and giving a taste for what they do.

Part three is entitled, "Which Person for Which Path," in which training program directors in the residencies of medicine, surgery, psychiatry, and pediatrics discuss their role in trying to be sure the round peg fits into the round hole and what happens when it doesn't.

The fourth section deals with national health policy and physicians participating in the debate from viewpoints and positions different from their medical background. One is the governor of a state, another the editor of a major medical journal, and the former Surgeon General, Joycelyn Elders. Her introduction contains the statement, "The interview for this chapter was done just as she (Elders) was getting ready to leave Arkansas for Washington. The subsequent course of events has received enough attention in the media to warrant no further comment here."

The last part deals with confronting the obstacles and setbacks of racial prejudice, malpractice litigation, and personal illness as experienced and articulated by three physicians who had to deal with these problems and how it effected them and their practice.

There is both a Prelude and a "What's Next?" part to the book. Both need to be read to get the flavor and intent of the author. This would be a good book for someone interested in becoming a doctor because the pathways chosen by the doctors are very different and serve to show that there is no one right pattern for medicine. It is a very diverse group in intellectual pursuit, talents, individual interest, and personality. They all agree that medicine is a fascinating profession that allows much freedom to choose at all levels of life and never ceases to stimulate the mind and imagination.

This reviewer would have liked to have seen it noted, that more doctors in private practice are being included in the work. The preponderance (about 65 percent) of the interviews were of members of the faculty of the University of Massachusetts Medical Center and represented the sentiments of the East coast as to the future of health care. The West coast had some representation, but the Midwest had almost none. More input from the private sector of medicine would have given a broader and hopefully a fairer picture of what the practice of medicine entails. A broader scope of opinion from around the country could have better served the reader and given another flavor to the whole subject of medical care.

The book is helpful for the individual who is contemplating a career in medicine to show that there is more than one way to "skin the cat" in the search to become a physician.

Still the book is helpful for the individual who is contemplating a career in medicine to show that there is more than one way to "skin the cat" in the search to become a physician. If it serves to make one more person secure in his or her resolve to pursue medicine as a career or if it prevents another from making a "mistake," then it has served a useful purpose. KMS

Managed care: it's been around a long time and it's not going away

David K Ross, MD
KMS Immediate Past President

Editor's note: Due to recent sporadic production of the Journal, Dr. Ross' Presidential Message was not published during his term in office. Instead, it is printed here with our sincerest apologies for the delay.

For many years at our local hospital medical meeting, every time we had a discussion about peer review, utilization review, anything else of a similar nature, we could always count on one of our elderly staff members, who began practice before I was born, to eventually stand up and make the comment, "fellows, we are never going to get away from all this until we get back to the old doctor-patient relationship." What I always assumed he was referring to was a return to the days when the patient went to the doctor, received services, and then paid the doctor directly out of their own pocket without the intervention of an insurance company or any other type of third party payer.

Frankly, returning to that situation never seemed very appealing to me since it would undoubtably result in an immediate and substantial decline in my standard of living. Not only would my income drop but my effectiveness as a physician would be diminished considerably. Many of the tests that I order would be a severe economic burden for most of my patients. More expensive things like CT's or MRI's would cause extreme hardship; routine surgeries would be looked on as a financial disaster; and, some of the real major miracles that we perform like joint replacement and cardiac surgery, would be totally out of reach for the general public.

In retrospect, the original doctor-patient relationship was probably managed care at its finest. Physicians were reimbursed on a fee-for-service basis, but they certainly had an incentive not to do services above and beyond what patients could pay since they would take the loss. Moreover that system had something that even the most sophisticated managed care systems now in existence still have failed to achieve in that the patients themselves had a direct and immediate interest in managing health care costs.

The elderly physician I mentioned is no longer around the Ark City Hospital staff and none of us have taken up his torch to continue to call for a return to the "good old days." We realize that health care is very important and,

by its nature, it is the type of service that people, by some vehicle, need to set money aside for. The need for medical care is the "rainy day" that people should, but often do not, save money for. I believe the recognition of this fact was what in the beginning led people down the pathway of health insurance.

Unfortunately, as things progressed, significant mistakes were made. Everyone would be entitled to their own opinion about what caused things to go wrong, but I think many of our problems began with the battle cry "health care is a right." This is a belief that came out of the late 60s, advanced by those who felt that we could and should treat health care like life, liberty and the pursuit of happiness. This idea completely ignored the fact that even then, and certainly now, we have learned how to do more for people than we could afford to do. The vision was that somehow health care should be "free" for everyone since it was something everyone needed. In retrospect this was of course tantamount to saying that since something is necessary it should be available without limitation to everyone. What happened was of course the same thing that would have happened had we said that since food is necessary for everyone we would set up the following system. All those who could afford it would pay for food insurance in advance and those who couldn't afford insurance would have it paid for them. Then everyone would just go to the grocery store whenever they wanted and get whatever they wanted. Had we done that of course all the steak and lobster would have disappeared immediately, and it wouldn't have been too long before even the broccoli was in short supply.

By the time I came into practice in 1977, things, in my opinion, were totally out-of-control. Most of the patients seemed to have some type of insurance and they were encouraged to use it freely. Since the health cost spiral had not been going on long enough, most people saw only their portion of the elephant and thought that since they had prepaid a fixed amount, the more services they consumed for that amount the better the deal they were getting.

Physicians, on the other hand, not only stood to benefit economically by providing more services, but also were generally trained to be as thorough as possible to achieve the appropriate diagnosis and treatment without much emphasis on the economic consequences. There were a lot of physicians that used health care dollars excessively for the sake of being thorough. There were also a few that used excessive health care dollars for the sake of personal enrichment. I have been told that it was a rare physician that unethically profited from the health insurance system. A rare disease to me is something that I will either never see or see only once or twice in my lifetime. By that standard, physicians who were unethically milking the system to enrich their own personal income were not a rare disease of the health care system. Physicians who spent very little time with their patients and ordered a lot of tests were rewarded much more richly than those who spent a lot of time with the patient and ordered a few tests.

Why didn't we police ourselves better? Because it was very hard. Most of us felt that it was a full time job just minding our own business and making sure that our own individual performance was up to proper standards without trying to look over somebody else's shoulder. We all recognized, as we still do, that each individual case involves a lot of judgement. All of us on utilization review committees found that we had the experience of questioning another physician's motives, only to find that, if we looked a little deeper, physicians usually had good justification for their actions. Utilization review boards typically had very little power to do anything more than just make recommendations. Regulatory bodies were similarly weak. There was the knowledge that if one were indeed dealing with an unethical physician, disciplinary action could be hazardous to your health since, through a lawsuit, that person could make your life miserable, perhaps for many years.

What is the point of all this discussion? The term managed care has been used so frequently and by so many different groups of people that it has become difficult to define. I have therefore chosen to approach this problem by describing the opposite of managed care and that would be of course unmanaged care. To me unmanaged care as described above means the practice of medicine and the delivery of health care without regard to the economic consequences or, worse yet, delivery of health care for the primary purpose of economic gain rather than for the primary goal of achieving the patients' improved and sustained good health.

There is a lot of resistance to the idea of managed care and I think it is appropriate that many of the short-term consequences of managed care should be disdained by physicians. The problems of access to care, loss of individuals'

I think that we are involved in a positive movement. I believe that we are going through the painful struggle of creating what will be a better system of health care delivery.

Managed Care

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choice of physician, increased red tape, decision-making by inadequately trained and improperly motivated individuals, and the all too frequent imposition of an adversarial relationship between the physician and patient, are all bad things. But are these indications that we are indeed headed in the wrong direction? Should we be striving for a return to the "unmanaged care" of the 1970s or clear back to the days when there was no insurance at all? I think not. I think that we are involved in a positive movement. I believe that we are going through the painful struggle of creating what will be a better system of health care delivery. We must solve the problems of access to care. We must learn how to deal with the fact that we cannot afford to do everything we would like to do for our patients. We must face the fact that although we provide a vital service we are not so important that we should be offended when people have concerns about how much we cost. Most importantly, I believe we should strive toward a system which does what the original totally private paid doctor-relationship did accomplish so well, motivate the patients as well as the providers to take a positive but practical approach to solving health care problems. We need a system that recognizes that although access to health care may be considered a right, health care itself is a service that has a cost and therefore cannot be unlimited.

If you are going to take a trip it is better to select a difficult road with a correct destination rather than an easy road that takes you to the wrong place. If we as physicians take the role of passengers on this trip through the evolution of managed care, not giving directions, but just griping about the bumps and bruises we are receiving, and wishing we could go back to where we started, we could wind up with the worst of both worlds, a difficult road to the wrong destination. We need to get in the driver's seat on this trip while we still can, although at times we may have to accept some of the guidance and advice of others. We should take an active part in establishing a vision of the future of health care delivery, cast our eyes forward, not backward and keep moving toward the goal. KMS

Geriatric Journal Club

Donald L Courtney, MD

Effects of Estrogen or Estrogen/Progestin Regimens on Heart Disease Risk Factors in Postmenopausal Women. The Postmenopausal Estrogen/Progestin Interventions (PEPI) Trial Writing Group. JAMA, *273:199-208, 1995*

THIS A IS RANDOMIZED, PROSPECTIVE study of four different regimens of estrogen, given to post-menopausal women with no contraindications to estrogen or progesterone therapy. The intent of the study is to determine the impact of the different regimens on several risk factors for heart disease. The need for this information is pressing; the incidence of heart disease rises sharply in the post-menopausal period. While estrogens appear to reduce the risk of heart disease, the use of unopposed estrogen places the woman at higher risk of endometrail cancer, but has appeared to reduce the benefit of estrogens on cardiovascular risk factors.

The study enrolled 875 women at seven sites. Subjects were between 45 and 64 years of age, their last menstrual period was one to 10 years prior to enrollment (greater than two months if the patient was surgically menopausal), and all were in good health. Baseline mammography and endometrial biopsies were performed on all subjects.

Subjects were randomized to one of five regimens: placebo, conjugated equine estrogen (Premarin) 0.625 mg/day [CEE], CEE plus medroxyprogesterone acetate (Provera) 10 mg/day for the first 12 days of a 28-day cycle [CEE+cyclic MEA], CEE plus MEA 2.5 mg/day continuously [CEE+cont MEA], or CEE plus micronized progesterone 200 mg/day for the first 12 days of a 28-day cycle [CEE+MP].

Patients were followed for three years. Attendance at follow-up appointments was 95 percent or better in all groups. Women in all groups were similar: the average age at enrollment was 56 years, about 90 percent of the subjects were white, about two-thirds were married, about one third had undergone hysterectomy.

RESULTS

Lipoproteins: Probably half of the cardioprotective effect of estrogens is their ability to raise the HDL-cholesterol. In this study, all estrogen protocols were associated with an increase in HDL-C over placebo. CEE alone and CEE+MP had the greatest increase in HDL-C. LDL-Cholesterol fell in all groups treated with estrogen regimens.

Triglyceride levels increased in all active treatment groups in this study. This is consistent with known effects of estrogen to increase triglyceride production. Although the authors of this study suggest that this increase in triglyceride production may not be atherogenic, the evidence to support this conclusion is not available.

Blood pressure: In this study, blood pressures were not different between the different groups over the course of the study.

Glucose and insulin: Fasting glucose levels decreased in subjects receiving active treatment, compared with placebo. This was accompanied by a decrease in plasma insulin levels in the treatment groups, confirming previous work that demonstrates estrogens have a beneficial effect on insulin resistance. Women on either of the MPA regimens had an increase in the two-hour glucose, suggesting glucose intolerance. It is reasonable to conclude that there is no net increase in diabetes on any study regimen, and that only MPA has an association with worsened glucose tolerance.

While estrogens appear to reduce the risk of heart disease, the use of unopposed estrogen places the woman at higher risk of endometrail cancer, but has appeared to reduce the benefit of estrogens on cardiovascular risk factors.

Increased thrombogenesis: Fibrinogen levels were measured serially during the study. There was a small, but significant reduction in fibrinogen levels for patients on active treatment.

Weight and waist-hip ratio: All groups had a net gain in weight; the greatest gain was in the placebo group, and the least weight gain among women with unopposed CEE. The waist-hip ration increased in all groups, without

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significant differences.

There were a large number of dropouts in the placebo and CEE groups. This reflected a higher rate of adverse events. Forty-one of 170 women receiving CEE had adenomatous or atypical hyperplasia requiring treatment. Half of all hysterectomies (seven of 14) were performed on subjects in the CEE group. There were no significant differences between groups in the rates of cancer or cardiovascular events. The difference in outcomes will be the subject of the next large prospective study of estrogens to be reported (the Women's Health Initiative, to be completed in 2000 or 2001).

COMMENTS

The PEPI trial answers a lot of questions that previous, non-randomized trials had not answered. The benefits of hormone replacement therapy are not all due to a selection bias of healthier women requesting estrogens (an issue that has confounded previous observational studies). Hormone therapy in current low doses does not increase clotting factors, nor does it adversely affect blood pressure or weight. The effect of hormone replacement on glucose and insulin is more complex and will need further study, but for now the practitioner can advise patients that treatment with CEE+MP does not worsen glucose tolerance.

The effect of hormone replacement therapy on lipoproteins is the most complex. CEE produces a beneficial effect on HDL-cholesterol (5.6 mg/dl increase). This effect is blunted by progestins, more so with MPA (1.2 and 1.6 mg/dl) than MP (4.1 mg/dl). All regimens lowered LDL-cholesterol by about 15 mg/dl. Triglycerides rose in all treatment groups by about 13 mg/dl. Theoretically, the overall changes in lipoproteins should produce a significant reduction in cardiovascular deaths.

CHANGING YOUR PRACTICE

There are certain groups of patients where the use of estrogens is controversial; these patients were not included in the PEPI study. At this time, it is unclear whether to provide estrogens to women with a history of stroke or heart disease. Estrogen therapy is contraindicated in women with a history of breast cancer, endometrial cancer or hypertriglyceridemia. In the absence of these conditions, women should be placed on estrogens near the time of menopause. This will produce reductions in osteoporosis, and likely reduce cardiovascular deaths as well. Although CEE+MPA (Premarin+Provera) would be least expensive, it appears that CEE+MP may have the greatest benefit on cardiovascular risk. At present, there is no commercially available preparation of micronized progesterone, but 28-day blister packs of CEE+Micronized Progesterone should be available by the time this reaches print. All patients on hormone replacement therapy should be followed with annual exams as outlined in the study.

As the accompanying editorial in *JAMA* (273:240-241, 1995) pointed out, current work showing benefits of hormone therapy reducing the risk of depression, memory loss, and a range of cancers shows a compelling need for increased, but careful use. KMS

Dr. Donald L. Courtney is the Chief of Geriatric Medicine at the Dwight G. Eisenhower V.A. Medical Center in Leavenworth, and an Assistant Professor of Medicine with the Center on Aging at the University of Kansas Medical Center.

Escherichia coli O157:H7 infections in Kansas, 1994-1995

BACKGROUND

AT LEAST FIVE GROUPS of Escherichia coli (EC) bacteria cause enteric illness: enterotoxigenic EC, enteropathogenic EC, enteroadherent EC, enteroinvasive EC, and enterohemorrhagic EC. These bacteria can cause a broad spectrum of disease, ranging from travelers' diarrhea to dysentery-like disease, to Hemolytic Uremic Syndrome (HUS). Each group of EC operates through a different mechanism and has slightly different symptoms.[1] Enterohemorrhagic EC type O157:H7 was recommended to be included in the list of reportable diseases by the Council of State and Territorial Epidemiologists in 1994 and is the focus of this article.

EC O157:H7 became known as a human pathogen in 1982 and was the cause of a widely known large outbreak of illness associated with hamburger consumption at a fast-food restaurant chain in 1991.[2] Between January 1, 1993 and September 14, 1995, 63 outbreaks of EC O157:H7 were reported from all regions of the country to the Centers for Disease Control and Prevention (CDC). Because EC O157:H7 is currently reportable in only 38 states and because only 54 percent of all clinical laboratories routinely screen bloody stools for EC O157:H7, it is believed to be a widely underreported infection.[3] One outbreak of EC O157:H7 in northeast Kansas was investigated by the Office for Epidemiologic Services and local health departments in the fall of 1995. EC O157:H7 became a reportable disease in Kansas in January, 1996.

REPORTED CASES IN KANSAS

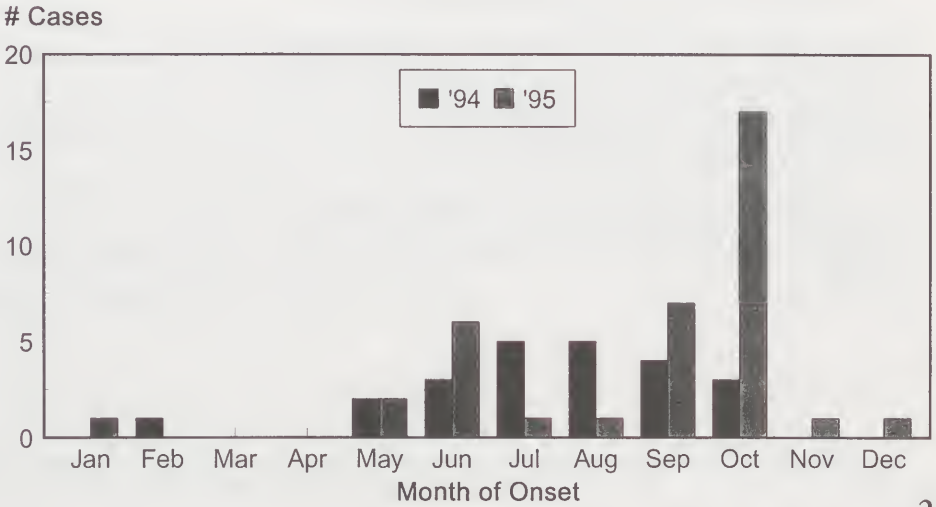
Prior to becoming a reportable disease, 59 EC O157:H7 infections with onset in 1994 and 1995 among Kansas residents were reported to the Office for Epidemiologic Services. The 1994 incidence rate of EC O157:H7 in Kansas was .92/100,000; and the 1995 incidence rate in Kansas was 1.45/100,000. The increase in reported cases is most likely due to an increase in the number of laboratories testing for EC O157:H7 and increased medical interest in infection detection and surveillance.

Age Distribution: The mean age of reported cases for both years combined was 25 years, with a range of 1-91 years. The incidence rate for children under five years old was almost four-times higher than that for older Kansans: 6.4/100,000 for 1994-95, compared to 1.7/100,000. This may be due to increased case finding and reporting in the youngest age group, in part because severe complications such as HUS are more likely to occur among young children, which increases the likelihood of detecting EC O157:H7 infection.

Seasonal Variation: Reported EC O157:H7 infections in Kansas exhibit a seasonal trend, with an increase in the summer/fall (Figure 1). This trend has been seen elsewhere and has been hypothesized to be related to increased exposure to undercooked beef and seasonal trends in the availability of fresh vegetables, fruits, and their products (e.g. unpasteurized apple cider), which can be sources of infection.

The large peak in cases in October 1995 was partially due to a point-source outbreak of EC O157:H7 infections after a wedding reception. The implicated food in that outbreak was mandarin orange punch and it is possible that a symptomatic food handler accidentally contaminated the punch.

Figure 1: Reported *E. coli* O157:H7 Infections, 1994-1995, Kansas



Escherichia coli 0157:H7

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Health Care Provider Role in EC O157:H7 Detection and Prevention

By suspecting and confirming EC O157:H7 infection, health care providers have an essential role in the investigation and control of outbreaks. The October 1995 outbreak investigation in Kansas also identified a missed opportunity to detect EC O157:H7 by stool culture: case (later confirmed through serological tests) provided bloody stool samples at two visits within a week of the wedding reception to a hospital emergency room but neither sample was tested for EC O157:H7. Many laboratories, including the Kansas Health and Environment Laboratory, will test for EC O157:H7 infection only upon specific request. It is essential, therefore, that physicians request the test in the presence of clinical suspicion of EC O157:H7 infection. The ability of a laboratory to detect EC O157:H7 from stool samples is enhanced when samples are collected in the early phase of infection. County health departments can assist with stool sampling and shipment to the Kansas Health and Environment Laboratory (KHEL) when EC O157:H7 is a potential cause of illness. Patients with diarrhea should be reminded to refrain from food preparation for others, especially outside the immediate family, and counseled to frequently wash hands with soap for at least 20 seconds, scrubbing underneath the fingernails. The skins of raw fruit should be washed thoroughly and kitchen countertops should be washed with soap after raw food has been present. The KDHE fact sheet on EC O157:H7 infection (page 33) may be copied and used for patient education. KMS

Editorial Note

Both cryptosporidiosis and EC O157:H7 became reportable diseases in Kansas on January 1, 1996. Outbreaks of these diseases can be prevented by appropriate food handling and hygiene practices, both of which can be influenced by health care providers' education of all patients.

This article was submitted by the Office for Epidemiologic Services, Kansas Department of Health and Environment (KDHE).

E. coli O157:H7 Infection

FACT SHEET

What is *E. coli* O157:H7?
There are many strains of bacteria named *Escherichia coli*, and most are normally present in human and animal intestines. The strain, *E. coli* O157:H7 is of special importance, however, because it can cause a variety of illness ranging from mild diarrhea to bloody stools and kidney failure, and may even result in death.

Who gets *E. coli* O157:H7?
Anyone may become infected, although children and the elderly are at a greater risk for the more severe complications of infection. Major sources of infection are undercooked ground beef and raw milk. Manure-contaminated fruits and vegetables can also be sources of infection.

What are the symptoms of *E. coli* O157:H7?
Diarrhea, sometimes bloody, is the most common symptom of *E. coli* O157:H7 infection. Abdominal cramps and vomiting are also symptoms of infection. Because these symptoms are common to a number of illnesses besides *E. coli* O157:H7 infection, it is important to have a stool sample tested for the presence of the bacteria early after the symptoms begin. A physician or local health department can arrange to have stool testing done.

How soon do symptoms appear?
Generally, symptoms begin 3-4 days after infection.

For how long is a person able to spread *E. coli* O157:H7?
While children can spread disease for up to 3 weeks, adults typically shed the bacteria for one week.

What is the treatment for *E. coli* O157:H7?
Antibiotics are used only in severe cases or to treat complications. If dehydration occurs, fluid replacement may be needed.

What can a person do to minimize the spread of *E. coli* O157:H7?
Infection can be prevented if ground beef is cooked until the pink is gone. Fruits and vegetables should be thoroughly cleaned before eating. Pasteurization kills bacteria in milk or apple cider. When someone develops *E. coli* O157:H7 infection, frequent handwashing with soap for at least 20 seconds, making sure to clean under the fingernails, will reduce the risk of spreading infection. Supervised handwashing of young children is important. Infected children in day care or food handlers should not return to their usual activities until two stool samples are negative for *E. coli* O157:H7.

Provided to you by the Kansas Department of Health and Environment, Office for Epidemiologic Services (913) 296-2951
Revised 5/96 from the CDC Briefs--Beware the Bacterium

Delegate's report from the AMA House of Delegates Interim Meeting

The AMA House of Delegates met in Atlanta, December 8-11, 1996. At the Opening Session there were 426 delegates seated representing every state and territory and also virtually every national specialty society.

Governance

The House adopted recommendations in a report of a Special Committee that provides for four-year terms with a maximum tenure of eight years. This is a change from the previous provisions of three three-year terms for a maximum tenure of nine years.

At the same time the House rejected proposals of the Special Committee that would expand the size of the Board by providing "slotted seats" to specified specialty categories and large group practices.

The House also voted to establish a new Section for International Medical Graduates (IMG). The Reference Committee noted the contributions of IMG's to medicine and the strong need and desire for a Section as an appropriate response to a growing segment of the physician population with special concerns. The committee also noted that there was potential for AMA membership growth among IMG's.

American Medical Accreditation Program (AMAP)

The House considered a Board report and three resolutions on the implementation of AMA's new program for setting standards for practicing physicians, called the American Medical Accreditation Program (AMAP). This program was developed in response to previous House actions calling on the AMA to ". . .support development of standardized criteria to be used in managed care contracts for reviewing physicians' office and medical records in order to avoid multiple review."

The Board detailed the extensive outreach conducted with the Federation since the 1996 Annual Meeting and believes the response from the Federation also reflects the spirit of

professional unity demonstrated in the action calling for promoting trust and cooperation throughout the Federation.

The Reference Committee reported that it heard testimony stressing the need to consolidate credentialing and physician office site review and supporting the AMAP program as a mechanism through which the Federation can work together to achieve this result.

The Reference Committee was assured that AMAP will employ the Federation concept and network with state, county, and specialty medical societies existing credential verification services and with commercial vendors who collaborate with Federation organizations.

The Reference Committee also reported that it heard testimony stressing the need to proceed without delay because of the pressing need of physicians for a consolidated effort in credentialing and physician office site review. Commercial vendors, HMO groups and others are beginning to or will soon develop their own verification programs. These efforts often proceed with little physician input.

The House approved as amended the recommendations in the Board report as follows:

1. That the AMA continue implementation of the American Medical Accreditation Program.
2. That periodic progress reports be disseminated to the Federation, and that the House of Delegates receive a progress report at each Annual and Interim Meeting.
3. That as AMAP implementation proceeds, the Board of Trustees continue to include Federation (county, state and specialty medical societies) and related organizations in every phase, including, appointment to the Governing Body; defining roles for each Federation component on the Advisory Committees; and the formation of partnerships with appropriate Federation organizations in each of the five components of AMAP.

HIV Counseling & Testing for Pregnant Women

After much debate in the Reference Committee and on the floor of the House of Delegates, the House voted to reaffirm existing policy on counseling and testing of pregnant women for HIV. The policy states: The AMA supports the position that there should be mandatory HIV testing of all pregnant women and newborns with counseling and recommendations for appropriate treatment.

In a related action the House adopted a substitute resolution that states: That physicians and other health care providers who are principally responsible for the prenatal care and delivery have a mandatory responsibility to provide information and counseling to pregnant women about the risk of vertical transmission of HIV and the benefits of treatment and a responsibility to document such counseling, testing and treatment results.

Many AMA policies and programs began with an individual physician who had a good idea and coaxed it through the democratic process.

Termination of Late Term Pregnancies

The Reference Committee reported that it heard extensive and passionate testimony on two resolutions opposing the termination of late term pregnancies. The committee noted that this issue is also related to the importance of the physician-patient relationship and the belief that governmental interference into the practice of medicine is inappropriate and ultimately harmful to the patient.

The committee proposed a substitute resolution, believing that it is important for the Association to assist in providing the scientific and clinical expertise to establish standards of good medical practice. The committee believed that the political and judicial decisions that society must make should be based on good science and good medicine.

After much debate the House adopted the following substitute resolution: That the AMA Board of Trustees, in consultation with pertinent AMA Councils and medical specialty societies, undertake a study of which late term pregnancy termination techniques and circumstances conform to the "standards of good medical practice" as required by current policy, and that the AMA work with pertinent medical specialty organizations to develop appropriate clinical practice guidelines for late term pregnancy termination.

Delegate's report

Continued from page 35

Funding of Graduate Medical Education

The Council on Medical Education provided a comprehensive study of the options for financing graduate medical education. This report is in response to a growing perception that the United States is training through graduate medical education (GME) a number of physicians that are beyond national requirements and that the excess is not to the national benefit.

This is coupled with the need to reduce the number of GME positions funded by Medicare and to restructure Medicare to a sounder fiscal basis. Although the Federal Government is the major financial supporter of GME, it has little control over the numbers or the distribution of GME opportunities other than through financial support.

The Council offered eight recommendations that were adopted as amended:

1. That the AMA affirm and support current policy for a Federal system of financing Graduate Medical Education based on an all payer contribution.
2. That the AMA affirm and support current policy for a Federally authorized public/private sector planning initiative to monitor, guide and distribute the funding from the all payer fund consistent with the need to improve Medicare fiscal solvency and to respond to regional and specialty needs.
3. That the AMA support the establishment of an authorization system yet to be specified (for example, a voucher system) to provide funding for the training program at the site where training occurs.
4. That the AMA support the development of a portable authorization system for use by the U.S. medical graduates, recognizing that the MD/DO degree is only a mid-point of formal medical education.
5. That the AMA support establishment of an authorization system which guarantees funding for U.S. medical graduates and additional funding for international medical graduates on a competitive basis, based on limits set by the new public/private sector workforce planning group.
6. That the AMA support the development of alternative options for support of teaching hospitals to achieve fiscal stability with reductions in Medicare Indirect Medical Education Adjustment payments and to develop alternative approaches to provide patient services previously provided by resident physicians.
7. That the AMA encourage the use of international assistance funds to provide for appropriate U.S. training for physicians from other countries to increase the level of medical care they would provide in their home countries.
8. That the AMA support efforts to allow completion of training of international medical graduates already in training who might be adversely affected by an authorization system.

Physician Workforce Development

At the Interim Meeting the AMA served as host for a distinguished group of professional organizations to hold an open hearing on the issue of physician workforce. About 1,000 physicians attended this historic meeting. Sponsors included the American Association of Colleges of Osteopathic Medicine, the American Osteopathic Association, the Association of Academic Health Centers, the Association of American Medical Colleges, the Institute of Medicine, the National Medical Association, and the American Medical Association.

The objective of this hearing was to provide an opportunity to hear testimony from all interested parties, develop a consensus statement to reflect the common themes of agreement, and then provide the Federal Government the very best advice on this issue. In addition to the oral testimony, many organizations submitted written statements. Dr. Richard F. Corlin, Speaker of the House of Delegates, presided.

Health System Reform

The House considered a report from the Council on Medical Service on employment-based health insurance plus a resolution sponsored by 13 state delegations entitled, "Individually Selected and Owned Health Insurance System Transformation."

The House amended the recommendations in the report calling on the AMA:

1. To place a high priority on implementation of current policy which supports equalizing the tax exemption of individually purchased health benefits with that of employer-based health benefits.
2. To continue to place a high priority on enactment of federal legislation to expand opportunities for employees

and others to individually own health insurance through vehicles such as medical savings accounts.

The House also adopted a substitute resolution that changed current AMA policy on this issue to read as follows:

1. Affirm its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services.
2. Actively support the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this the AMA will:
    a. Support legislation that would provide the employer with the same tax treatment for payment of health insurance premiums whether the employer provides the health insurance plan for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance.
    b. Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly.
    c. Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage.
    d. Work toward establishment of safeguards, such as a health care voucher system, to ensure that contributions made to the employee for the purchase of individually selected and individually owned health insurance are used for that purpose.
    e. To ensure that the health insurance plan purchased by the individual employee is sufficient to provide a basic level of health care and does not increase the probability that the employee will become uninsured, the AMA would work toward the establishment of the following guidelines: (1) minimum benefit requirements, including catastrophic protection, (2) fiscal solvency of the plan, (3) provision of basic consumer information, (4) protection of the consumer from fraud, (5) guaranteed issue, (6) guaranteed renewability, and (7) rate reform.

The House also revised the policy to call on the AMA to support individually selected and individually owned health insurance as the preferred method for people to obtain health insurance coverage.

Conclusion

Limited space prevents comment on everything that was considered by the House of Delegates.

Meetings of the AMA House of Delegates are open to every member and are conducted in a most democratic manner. They provide those who attend a unique educational experience as a wealth of information is disseminated and discussed. Members may present testimony at the Reference Committee hearings and there are many other opportunities to get your views across.

If you cannot come to the meetings, let your delegation know your opinions and concerns.

Many AMA policies and programs began with an individual physician who had a good idea and coaxed it through the democratic process. KMS

Your delegation from Kansas includes:

Jimmie A. Gleason, MD, Topeka; *Delegate*
Stephen F. Miller, MD, Parsons; *Delegate*
Linda D. Warren, MD, Hanover; *Delegate*
Kermit G. Wedel, MD, Minneapolis; *Delegate*
Craig A. Concannon, MD, Beloit; *Alternate Delegate*
Joseph C. Meek, Jr., MD, Wichita; *Alternate Delegate*
Terry L. Poling, MD, Wichita; *Alternate Delegate*
Roger D. Warren, MD, Hanover; *Alternate Delegate*

I testify in court

Arthur Hertzler, MD

MY TEACHING position brought me some autopsies and as a consequence demands to testify in court. I learned that the game is to cause you to swear that you will tell "the truth, the whole truth, and nothing but the truth," and then the lawyers battled to see to it that you did not do any of the three things you were under oath to do. But it was a lot of fun. Unfortunately for the lawyers, I was not so dumb and timid as I looked. I soon learned that if I played the smart game they played with me it was all right with the judge. One thing one could count on in the beginning of cross questioning: I never used any money I received as an expert witness for my own use. I gave all the fees to Mercy Hospital because I wanted to make sure I would never testify for money. It was a common practice with lawyers to make the jury feel that the medical expert was to receive a large fee: therefore, the testimony must, of necessity, be prejudiced. I would parry with the attorney as long as I could draw him out. Then I would offer to make a pact with him to give the hospital above mentioned the whole fee each of us received, adding quickly that it was my practice invariably to do so. Of course, an assistant lawyer would move to "strike out, incompetent, irrelevant, and immaterial." But the jury got a laugh and somehow no lawyer seems to like to have a jury laugh at him. Lawyers have a small sense of humor.

One instance may be mentioned. I was testifying in a notorious case. The opposing lawyer was a very able man, large of physique and positive of language. When he came to cross-question me he walked near the witness stand and fairly bellowed his question. I looked at him calmly a moment and then placed my hand behind my ear and meekly said, "A little louder, please." Everybody bellowed with joy. The lawyer was so mad he sank in his chair and his assistant had to follow up the cross-questioning. The morning paper had a headline: "Prominent attorney did not scare the modest young doctor."

. . . there seem to be doctors available for testifying to anything a lawyer may wish them to do.

Another prominent attorney once became peeved at me for insisting that the nursery yarn of the cow jumped over the moon violated no rule of logic and was as plausible as the point he wished to establish: to wit, that a plump lady could produce a displacement of the uterus by sitting down in the vestibule of a streetcar. The judge allowed us to wrangle quite awhile and then said to the lawyer: "You asked the question and I would suggest you allow the doctor to answer it, as he seems determined to. And then we can all go home to supper." My idea was that in as much as I was not permitted by any lawyer to tell my part of the truth, I retaliated the best I could by keeping him from establishing something that certainly was not true.

As I became busier I came to avoid court service as being too time consuming and the labor of avoiding the traps of clever lawyers too exhausting. Besides, it is not particularly edifying to have the average jury ponder on the correctness of the conclusions of a medical witness. At the same time one cannot blame them, for there seem to be doctors available for testifying to anything a lawyer may wish them to do. KMS

The Horse and Buggy Doctor *was written by Arthur Hertzler, MD, a Halstead physician. It recounts the practice of medicine as it was during Hertzler's career. The piece is reprinted with permission from the Hertzler Foundation.*

A moment of silence . . .

Clovis W Bowen, MD

Dr. Bowen, 84, a Topeka general practitioner, died December 18, 1996.

He graduated from the University of Kansas School of Medicine in 1937. He was a flight surgeon in the Army Air Corps from 1942 to 1946. He practiced medicine in Topeka and Valley Falls.

Dr. Bowen married Helen Williams in 1938. She preceded him in death in 1989.

He served on the board of directors of Blue Cross and Blue Shield from 1968 to 1971. He was a member of the Shawnee County Medical Society where he served as president in 1959. He was also a member of First United Methodist Church and the Downtown Rotary Club.

Caroline C Brown-Sanders, MD

Dr. Brown-Sanders, 84, a retired public health physician, died January 14, 1997 in Lee's Summit, Missouri.

Dr. Brown-Sanders was one of the first women graduates of the University of Kansas School of Medicine in 1936.

She married Dr. George E. Sanders in 1938. He preceded her in death in 1984.

Dr. Brown-Sanders was a member of Alpha Omega Alpha Honorary Medical Society and Alpha Epsilon Iota, Omicron Chapter Women's Medical Society. She served on a number of boards in Wyandotte and Clay County, Missouri and was assistant director of the Wyandotte County Health Department from 1961 until her retirement in 1972.

Edwin Wray Enders, MD

Dr. Enders, 93, a retired anesthesiologist at Providence and St. Margaret's hospitals in Kansas City, died September 21, 1996 in Shawnee Mission.

He graduated from the University of Kansas School of Medicine in 1936. He was a Major in the United States Army Medical Corps during World War II.

Dr. Ender married Marguerite Lebo in 1930. She preceded him in death in 1989.

He was a member of the Lenexa United Methodist Church and the KU Alumni Association.

William S Fast, MD

Dr. Fast, 85, a retired Atchison family practitioner, died April 17, 1997 in Kansas City, Missouri.

He graduated from Creighton University, Omaha, Nebraska. He served as a physician in World War II. He served on inactive duty from 1947 to 1951 and was discharged as a Major, Medical Corps U.S. Army.

Dr. Fast married Jane Adele Poindexter in 1940. She survives.

He was a member of the Trinity Episcopal Church, Phi Gamma Delta fraternity, the Phi Rho Sigma Medical Fraternity, the Active Masonic Lodge #158 AF & AM, and he served on a number of boards in the Atchison area. He was the first physician to be a member of the Atchison Hospital Board of Directors.

Robert M Fenton, MD

Dr. Fenton, 76, a Garden City family physician, died September 29, 1996 in Garden City.

He graduated from the University of Kansas School of Medicine, in 1954. He served in the U.S. Army Air Corps with the 8th Air Force during World War II and was a POW for more than 18 months.

Dr. Fenton married Cathy Richards in 1979. She survives.

He was a member of First Christian Church and Rotary. He also served on various committees and boards in the community and taught photography at Garden City Community College.

Edward D Funk, MD

Dr. Funk, 92, a Eudora retired anesthesiologist, died April 29, 1996.

He graduated from the University of Kansas School of Medicine and was a member of the Wyandotte Medical Society.

Ted M Gardiner, MD

Dr. Gardiner, 48, a former Garden City pediatrician, died March 24, 1997 in Boulder Colorado.

He graduated from the University of Southern California School of Medicine in 1974.

Dr. Gardiner married Lynda Sherri Godber in 1972. She survives.

He was a member of the Order of the Arrow and Alpha Chi Sigma, Delta Upsilon. As a professional, he directed continuing medical education in Kansas and was a member of the American Academy of Pediatrics.

C B Harris Jr, MD

Dr. Harris, 79, a retired family practitioner, died November 17, 1996.

He practiced in the Garnett area for many years. He served with the U.S. Army during World War II.

Dr. Harris married Donna B. Rewerts in 1941. She preceded him in death in 1994.

He was a member of First Methodist Church, Delphian Lodge No. 44, AF & A M, the American Legion, Anderson County Medical Society, Trinity Lutheran Hospital Board of Directors, and the Kansas Historical Society.

Lawrence "Larry" Hart Sr, MD

Dr. Hart, 64, a retired family practitioner, died December 24, 1996 in Atchison.

He graduated from the University of Kansas School of Medicine in 1964. He was a Navy veteran. He served as the sports team doctor for Maur Hill High School and Benedictine College.

Dr. Hart's wife, Joanne, survives.

He was a member of the Atchison Medical Society, Knights of Columbus, Elks Lodge, and was active with various other organizations in the Atchison area. He was the recipient of the Kansas Monk Award from Benedictine College.

Robert G Heasty, MD

Dr. Heasty, 85, a Manhattan obstetrician and gynecologist, died March 17, 1997 in Manhattan.

He graduated from New York University School of Medicine in 1938. He moved to Manhattan in 1946 and was the first obstetrics-gynecology physician in Manhattan. He served in the Air Force during World War II.

Dr. Heasty married Harriet Allen in 1939. She preceded him in death in 1993.

He served as president of the Riley County Medical Society and one term as president of the Kansas Obstetrical Society. He was a life fellow of the American College of Obstetrics and Gynecology and he served 30 years on the former Maternal Health Committee of the Kansas Medical Society.

F W Huston, MD

Dr. Huston, 90, a retired Winchester family physician, died February 13, 1997 in Winchester.

He graduated from Rush Medical College in 1933 and began his family practice in Winchester in 1934.

Dr. Huston married Zetta Grace McCoy in 1934. She preceded him in death in 1995.

He was a member of the American Academy of Family Physicians, the Reformed Presbyterian Church and the Lions Club.

A Moment of Silence . . .

Continued from page 41

Hiram "Penny" Jones, MD

Dr. Jones, 90, a retired Lawrence surgeon, died January 26, 1997 in Lawrence.

He graduated from the University of Kansas in pre-med in 1928 and was graduated from Harvard University in 1931. He served as head of the orthopedic hospital in the African Theater of operations during World War II and his unit followed General George Patton through Africa, Italy and France.

Dr. Jones married Frances Carolyn Foulkes in 1933. She survives.

He was a team physician for the Lawrence High School football team for 28 years. He was a member of Alford-Clarke Post No. 852 of the Veterans of Foreign Wars, Dorsey-Liberty Post No. 14 of the American Legion, the Rotary Club, and the Big Blue Club.

William A Leo, MD

Dr. Leo, 75, a retired emergency medicine physician, died December 1995.

He graduated from the University of Kansas School of Medicine.

Frederick Matassarin, MD

Dr. Matassarin, 82, a retired Wichita urologist, died October 29, 1996 in Wichita.

He earned his BS in medicine at the University of Kansas and his MD there in 1937. He spent five years in the military as chief of urology at Fort Benning, GA, and at a U.S. military hospital in England.

Dr. Matassarin's father, Dr. Leon Matassarin, and brother, Dr. Ben Matassarin, were also Wichita physicians.

John F Nienstedt, MD

Dr. Nienstedt, 88, a retired Hartford obstetrician, died July 27, 1996 in Sun City, Arizona.

He graduated from the University of Kansas School of Medicine. He served as a Captain overseas in the U.S. Army Medical Corps during World War II.

Dr. Nienstedt's wife, Pauline Price, survives.

He was a member of the Lakeview United Methodist Church.

George W Pogson, MD

Dr. Pogson, 71, a retired internal medicine physician, died August 22, 1996 in Pittsburg.

He graduated from the University of Kansas School of Medicine in 1947. He served in the U.S. Navy V-12 Unit during World War II. He was a captain in the U.S. Army during the Korean Conflict, and was stationed at the Tokyo Army Hospital.

Dr. Pogson married Mary Estelle Miller in 1949. She survives.

He was a past president of the Crawford County Medical Society, chief of staff at Mt. Carmel Medical Center, a past member of the Mt. Carmel Trustees and a Fellow of the American College of Physicians. He was a active in many civic and community organizations in the Pittsburg area as well as a member of First United Methodist Church.

Vaughan C Price, MD

Dr. Price, 91, a retired general surgeon, died February 19, 1997 in McPherson.

He practiced in McPherson for 62 years. He graduated from the University of Tennessee in 1929. He served in the U.S. Navy from 1942 to 1945.

Dr. Price served 40 years as the athletic physician at McPherson College. He was presented a Distinguished Service Award for his community service in 1986. He was a member of the Rotary Club and held the record for 44 years of perfect attendance.

David M Pugh, MD

Dr. Pugh, 67, a Kansas City cardiologist, died March 11, 1997. He graduated from Yale University School of Medicine.

James S Reed, MD

Dr. Reed, 73, former Douglas County coroner, died March 20, 1997 in Lawrence.

He graduated from the University of Kansas School of Medicine in 1947. He entered the Navy during World War II and was commissioned in the Navy Medical Corps. He served as the physician for the crew of the Nautilus atomic submarine. Dr. Reed entered the foreign medical service of the United States State Department. He served as medical attaché for embassies and consulates in Vietnam, Nepal, Ethiopia, Kuwait, and Uruguay.

Dr. Reed married Pauline "Polly" Rankin in 1951. She survives.

J D Smith, MD

Dr. Smith, 74, a retired Larned family physician, died November 12, 1996 in Salina.

Dr. Smith also practiced medicine in Santana for 10 years during the 1960s. He served in the U.S. Army during World War II.

Dr. Smith married Wilma Jean Cook in 1948. She preceded him in death in 1988. He married Helen Pfaff in 1991. She survives.

He was a member of the United Methodist Church of the Cross, the American Legion and the Veterans of Foreign Wars.

Cornelius J P Sullivan, MD

Dr. Sullivan, 78, a retired Wichita obstetrician and gynecologist, died June 18, 1996 in Fishkill, New York.

He graduated from New York Medical College and established a practice in New York state. In 1975 he came to Wichita and established his obstetrical & gynecologic practice.

His wife Rita survives.

Lawrence E VinZant, MD

Dr. VinZant, 85, a retired Wichita surgeon, died November 4, 1996 in Wichita.

He graduated from the University of Kansas School of Medicine. He served in the U.S. Navy from 1944 to 1946.

William T West, MD

Dr. West, 72, retired Wichita obstetrician and gynecologist, died February 4, 1997.

His wife, Regina survives.

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